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Commission on Population and Development

Forty-second session

30 March-3 April 2009

Item 2 of the provisional agenda

Adoption of the agenda and other organizational matters

Provisional agenda

1. Election of officers.
2. Adoption of the agenda and other organizational matters.
3. Follow-up actions to the recommendations of the International Conference on Population and Development.
4. General debate on national experience in population matters: contribution of the Programme of Action of the International Conference on Population and Development to the internationally agreed development goals, including the Millennium Development Goals.
5. Programme implementation and future programme of work of the Secretariat in the field of population.
6. Contribution of population and development issues to the theme of the annual ministerial review in 2009.
7. Provisional agenda for the forty-third session of the Commission.
8. Adoption of the report of the Commission on its forty-second session.

Annotations

1. Election of officers

Rule 15 of the rules of procedure of the functional commissions of the Economic and Social Council stipulates that the Commission shall elect, from among the representatives of its members, a Chairman, one or more Vice-Chairmen and such other officers as may be required.

In accordance with its decision 2004/2, the Commission, immediately following the closure of its forty-first session, held the first meeting of its forty-second session for the sole purpose of electing the new Chairman and other officers of the



Commission. The following officers were elected by acclamation: Chairman: Elena Zúñiga Herrera (Mexico); Vice-Chairpersons: Ivanka Tasheva (Bulgaria); Raja Nushirwan Zainal Abidin (Malaysia); Yera Ortiz de Urbina (Spain); Irene Bwalya Muloshi Tembo (Zambia).

2. Adoption of the agenda and other organizational matters

Rule 7 of the rules of procedure of the functional commissions of the Economic and Social Council requires that the Commission shall, at the beginning of each session, adopt the agenda for that session on the basis of the provisional agenda.

On the recommendation of the Commission at its forty-first session, the Council, in its decision 2008/240, approved the provisional agenda and documentation for the forty-second session of the Commission.

At its thirtieth session, the Commission decided to authorize its Bureau to hold intersessional meetings in preparation for its sessions on a yearly basis. At its thirty-ninth session, in its resolution 2006/1, the Commission requested its Bureau to meet as frequently as necessary in preparation of its annual sessions. The Commission has before it the report of the Bureau on its intersessional meetings.

Documentation

Provisional agenda (E/CN.9/2009/1)

Report of the Bureau of the Commission on Population and Development on its intersessional meetings (E/CN.9/2009/2)

Note by the Secretariat on the organization of work of the session (E/CN.9/2009/L.1)

3. Follow-up actions to the recommendations of the International Conference on Population and Development

In its resolution 49/128, in which it endorsed the recommendations of the International Conference on Population and Development, the General Assembly decided that the Commission, as a functional commission assisting the Economic and Social Council, would monitor, review and assess the implementation of the Programme of Action of the Conference at the national, regional and international levels and advise the Council thereon.

In the terms of reference of the Commission,¹ which were endorsed by the Council in its resolution 1995/55, the Commission was called upon to adopt a topic-oriented and prioritized multi-year programme. That work programme, inter alia, would provide a framework for assessing the progress achieved in the implementation of the Programme of Action. In its report on its twenty-eighth session, of which the Council took note in its decision 1995/236, the Commission called for the preparation of annual reports on a selected topic of the Programme of Action.²

At its twenty-first special session, the General Assembly, in its resolution S-21/2, adopted the key actions for the further implementation of the Programme of Action.

¹ See *Official Records of the Economic and Social Council, 1995, Supplement No. 7 (E/1995/27)*, annex I, sect. I.A.

² *Ibid.*, sect. III.

In its decision 2007/1, the Commission reaffirmed that the special theme for the forty-second session in 2009 shall be "Contribution of the Programme of Action of the International Conference on Population and Development to the internationally agreed development goals, including the Millennium Development Goals".

Documentation

Report of the Secretary-General on world population monitoring, focusing on the contribution of the Programme of Action of the International Conference on Population and Development to the internationally agreed development goals, including the Millennium Development Goals (E/CN.9/2009/3)

Report of the Secretary-General on the monitoring of population programmes, focusing on the contribution of the Programme of Action of the International Conference on Population and Development to the internationally agreed development goals, including the Millennium Development Goals (E/CN.9/2009/4)

Report of the Secretary-General on the flow of financial resources for assisting in the implementation of the Programme of Action of the International Conference on Population and Development (E/CN.9/2009/5)

4. General debate on national experience in population matters: contribution of the Programme of Action of the International Conference on Population and Development to the internationally agreed development goals, including the Millennium Development Goals

The Commission has concluded that it would be useful to make provision in its agenda for a general debate on population matters relating to the topic of the Commission's focus, during which Government views and national experiences could be exchanged.

5. Programme implementation and future programme of work of the Secretariat in the field of population

At its twenty-eighth session, the Commission suggested that the work programme in the field of population should continue, inter alia, to give high priority to the monitoring of population trends and policies; undertake the biennial preparation of estimates and projections of global, national, urban, rural and city populations; conduct studies on population and related development policies; prepare studies on interactions of population change; carry out analyses of mortality; contribute to and coordinate in-depth studies on fertility, nuptiality and reproductive rights and health, including family planning; undertake studies to improve the understanding of the causes and consequences of internal migration and international migration; increase public awareness of and information exchange on population and development issues; make the necessary arrangements for coordinating the review and appraisal of the Programme of Action; and provide technical cooperation support to developing countries, particularly the least developed countries, and, on a temporary basis, to countries with economies in transition in the light of the economic and social problems that those countries faced at that time.³

³ *Report of the Second World Assembly on Ageing, Madrid, 8-12 April 2002* (United Nations publication, Sales No. E.02.IV.4), chap. I, resolution I, annex II.

The Commission reaffirmed the content of the work programme at its twenty-ninth session (Commission resolution 1996/1).

At its thirtieth session, the Commission stressed the importance of continuing the basic work of the Population Division of the Secretariat on the crucial underpinnings of population estimates and projections; basic population trends and issues, including fertility, mortality, migration and patterns of rural and urban population change; the evolution of population policies; and understanding of the links between population and development (Commission resolution 1997/3).

At its thirty-seventh session, the Commission reaffirmed the importance of the work of the Population Division in providing the United Nations system and the international community with comprehensive and scientifically sound inputs for the analysis of progress made in achieving the goals and objectives on population and development set in the outcomes of major United Nations summits and conferences, especially the Programme of Action of the International Conference on Population and Development, the key actions for its further implementation and the Declaration of Commitment on HIV/AIDS (Commission resolution 2004/1).

The Commission further emphasized that the Population Division should continue basic work on population estimates and projections; patterns of rural and urban population change; the analysis of international migration; the implications of the changing age structure of the population for development; the increasing diversity of fertility and mortality levels and trends; the interrelations among population, resources, the environment and development; and the evolution of population policies, applying a gender perspective in this regard (Commission resolution 2004/1).

The Economic and Social Council, in its resolution 1996/2, requested that main demographic trends be covered biennially, starting in 1997, in a concise report prepared by the Population Division, to be discussed under the agenda item concerning the work programme of the Division.

As indicated in the biennial programme plan and priorities for the period 2008-2009,⁴ the objective of the subprogramme in population is to promote policy debate on current and foreseeable population issues at the national and international levels with a view to enabling Member States to address population and development issues effectively. Paragraph 7.13 of the biennial programme plan designated the Population Division as the body responsible for the subprogramme and mandated the Division to achieve this objective by (a) providing substantive servicing to United Nations bodies, especially to the Commission on Population and Development, and assessing progress made in the implementation of the Programme of Action of the International Conference on Population and Development; (b) facilitating the discussion of key or emerging population issues by experts or Government representatives; (c) preparing comprehensive studies on population issues and population trends relating to fertility, mortality, international and internal migration, HIV/AIDS, urbanization, population growth, population ageing, population prospects, population policy and population in relation to development; (d) disseminating population information and policy-relevant findings in the area of population, particularly through the Population Division website; and (e) building

⁴ A/61/6 (Prog. 7).

capacity to address population issues at the national level through workshops or the dissemination of technical material, such as manuals and software.

The Commission has before it for consideration the draft programme of work of the Population Division for the biennium 2010-2011. The Commission is invited to review the proposed draft programme of work and provide its comments.

Documentation

Report of the Secretary-General on world demographic trends (E/CN.9/2009/6)

Report of the Secretary-General on programme implementation and progress of work in the field of population, 2008 (E/CN.9/2009/7)

Draft programme of work of the Population Division, Department of Economic and Social Affairs, for the biennium 2010-2011 (E/CN.9/2009/CRP.1)

6. Contribution of population and development issues to the theme of the annual ministerial review in 2009

At its forty-first session, the Commission heard an address by the President of the Economic and Social Council on the various ways in which the Commission might contribute to the new mandates of the Council, in particular the annual ministerial review. In response, the Commission added this item to the agenda of its forty-second session in order to consider the contribution it could make to the annual ministerial review in 2009, whose theme will be: "Implementing the internationally agreed goals and commitments in regard to global public health". The Bureau of the Commission decided to invite the President of the Council to address the Commission under this item in order to launch a discussion on the contribution of population and development issues to the implementation of the internationally agreed goals and commitments in regard to global public health.

7. Provisional agenda for the forty-third session of the Commission

In accordance with rule 9 of the rules of procedure of the functional commissions of the Economic and Social Council, the Commission will have before it the draft provisional agenda for its forty-third session, together with an indication of the documents to be submitted under each item and the legislative authority for their preparation, in order to enable the Commission to consider those documents from the point of view of their contribution to the work of the Commission and of their urgency and relevance in the light of the current situation.

The attention of the Commission is drawn to Council resolutions 1979/41 and 1981/83 on the control and limitation of documentation. In addition, the Commission is reminded that the Council, in paragraph 1 (j) of resolution 1982/50 on the revitalization of the Council, urged all its subsidiary bodies to exercise the utmost restraint in making requests of the Secretary-General for new reports and studies and to implement fully the provisions of the decisions of the Council and of the General Assembly with respect to the control and limitation of documentation.

The attention of the Commission is also drawn to paragraph 4 of the annex to Council resolution 1982/50, in which the Secretary-General recommended that (a) the documentation and programme of work of the subsidiary bodies of the Council and the Assembly be streamlined in order to enable the subsidiary bodies to

perform effectively the functions entrusted to them; (b) the Council and the Assembly continue to review the provisional agendas for their subsidiary bodies, together with the list of requested documentation, in order, inter alia, to establish greater consistency in the overall request for documentation and its orderly consideration at the intergovernmental level, taking fully into account the medium-term plan and the programme budget; and (c) in doing so, the Council and the Assembly also take into account the need for the consolidation of items and documentation for their subsidiary machinery.

Furthermore, in its resolution 1981/83, the Council instructed its subsidiary bodies to take urgent measures to streamline their agendas and programmes of work and to bring about a substantial reduction in their requests for documents, bearing in mind the duration and the cycles of their meetings, and to report to the Council on measures adopted, taking strictly into account the guidelines set forth in the pertinent resolutions and decisions of the Council and the Assembly.

In decision 1983/163, the Council requested the Secretary-General (a) to bring to the attention of intergovernmental and expert bodies, before decisions were adopted, any request for documentation that exceeded the ability of the Secretariat to prepare and process on time and within its approved resources; and (b) to draw the attention of intergovernmental bodies to areas where duplication of documentation was likely to occur and/or where opportunities for integrating or consolidating documents that dealt with related or similar themes might exist, with a view to rationalizing documentation.

Documentation

Note by the Secretariat containing the draft provisional agenda for the forty-third session of the Commission (E/CN.9/2009/L.2)

8. Adoption of the report of the Commission on its forty-second session

In accordance with rule 37 of the rules of procedure of the functional commissions of the Economic and Social Council, the Commission shall submit a report to the Council on the work of each session.

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Item 2 of the provisional agenda*

Adoption of the agenda and other organizational matters**Report on the meetings of the Bureau of the Commission
on Population and Development****I. Introduction**

1. At its thirtieth session, in 1997, the Commission on Population and Development authorized the Bureau to hold intersessional meetings in preparation for its sessions.¹ In 2006, in resolution 2006/1 on its methods of work, the Commission requested its Bureau to meet as frequently as necessary in preparation for the annual sessions of the Commission. The Commission also stressed the importance of making written reports on the meetings of the Bureau.² In accordance with resolution 2006/1, the Bureau held two meetings in New York on 21 October and 15 December 2008.

2. The first meeting of the Bureau, on 21 October 2008, was attended by Elena Zúñiga Herrera (Chairperson) via teleconference. Present also were Ivanka Tasheva, Raja Nushirwan Zainal Abidin, Yera Ortiz de Urbina and Irene Bwalya Muloshi Tembo. Present at the second meeting of the Bureau, on 15 December 2008, were Ms. Zúñiga (Chairperson), Ms. Tasheva, Mr. Abidin, Ms. Ortiz de Urbina and Ms. Tembo. The Director of the Population Division of the Department of Economic and Social Affairs and a representative of the United Nations Population Fund (UNFPA) were present at all meetings of the Bureau.

3. The present report summarizes the discussions of the Bureau at those meetings as well as the conclusions reached and the recommendations made.

* E/CN.9/2009/1.

¹ *Official Records of the Economic and Social Council, 1997, Supplement No. 5 (E/1997/25), para. 52.*

² Commission on Population and Development decision, 2005/2.



II. Summary of the deliberations of the Bureau

A. Organization of work for the forty-second session of the Commission

4. The Bureau reviewed the organization of work for the forty-second session and found it acceptable.

B. Keynote speakers

5. At its thirty-eighth session, in its decision 2005/2, the Commission welcomed the format of inviting keynote speakers to the sessions of the Commission and requested the Bureau to make the necessary arrangements for their participation and to inform members accordingly. In accordance with that decision, the Bureau, after discussing the issue, decided that three keynote speakers would be invited to address the Commission on the special theme "The contribution of the Programme of Action of the International Conference on Population and Development to the internationally agreed development goals, including the Millennium Development Goals" and that each speaker would be allotted an hour to make a presentation and have an interactive dialogue with members of the Commission. The Bureau selected David Canning, Jean-Pierre Guengant and Zeba Sathar as keynote speakers. Mr. Canning, Professor at the Department of Global Health and Population, Harvard University, would be invited to speak on "Population growth and changing age structures: implications for the achievement of the Millennium Development Goals". Mr. Guengant, Director of the Institute for Research and Development in Ouagadougou, would be asked to speak on "The impacts of population growth on the least developed countries, with special emphasis on the role of reproductive health". Ms. Sathar, Senior Programme Associate with the Population Council in Islamabad, would speak on "Gender, population and the achievement of the Millennium Development Goals". As has become customary, the Bureau recommended that the working group be adjourned during the presentations made by keynote speakers.

C. Participation of relevant United Nations entities in the Commission on Population and Development

6. The Bureau noted that the topic of the forty-second session was relevant for a number of United Nations entities, such as the Food and Agriculture Organization of the United Nations, the International Labour Organization, the United Nations Development Programme, the United Nations Educational, Scientific and Cultural Organization, the United Nations Children's Fund, the United Nations Development Fund for Women, the World Health Organization, the United Nations University and others. Thus, the Bureau requested the Chairperson of the Commission to encourage relevant agencies, funds and programmes of the United Nations system to participate in the Commission's session and to invite them to consider organizing side-events during the session. As in other sessions of the Commission, the Bureau welcomed the involvement of UNFPA in organizing a side-event to the forty-second session.

D. Communication of the Chairman with members of the Commission

7. The Bureau requested its Chairperson to send a letter to the members of the Commission underscoring the need to have technical representatives attend the forty-second session, that is, specialists in population and development, public health and population policy. The letter would also provide guidance to members of the Commission regarding the items under which statements could be made and would outline the relevance of the various items on the agenda of the forty-second session. Information about how to have access to preliminary versions of the documentation for the session would also be included. The letter would also explain the proposed ways for the Commission to contribute to the 2009 annual ministerial review by the Economic and Social Council on the theme of "Implementing the internationally agreed goals and commitments in regard to global public health".

E. Relationship of the Commission on Population and Development with the Economic and Social Council

8. The Bureau noted that Ivan Piperkov, Chairperson of the forty-first session of the Commission, in consultation with the current Chairperson, Elena Zúñiga Herrera, had made a statement to the 2008 annual ministerial review of the Economic and Social Council in which he had stressed the importance of slowing population growth to facilitate adjustment to climate change and the mitigation of problems related to that change.

9. Ms. Zúñiga Herrera informed the Bureau that, in her capacity as Chairperson of the Commission, she had participated in a panel discussion held during the 2008 session of the Economic and Social Council on ways of combating violence against women. In her statement, Ms. Zúñiga had built on the statements made by Commission members during the consideration of that topic at the fortieth session and had underscored the commitment to eliminate violence against women of all ages that had been reflected in the resolution adopted at that session.

10. The Bureau was informed about the meeting that would be convened in New York on 27 January 2009 between the Bureau of the Economic and Social Council and the chairs of the functional commissions to discuss the various ways in which the functional commissions might contribute to the annual ministerial review. The Chairperson suggested that there were several ways in which the Commission could contribute: (a) by requesting, once more, that the Chairperson of the Commission make a statement at the annual ministerial review to highlight the contributions of population and development issues to the implementation of the internationally agreed goals and commitments in regard to global public health; (b) by inviting the President of the Council to address the Commission under item 6 of its agenda for the forty-second session in order to launch a discussion on the relevance of population issues to the attainment of the goals and commitments on global public health; and (c) by requesting the Secretariat to look into the possibility of organizing a side-event at the time of the annual ministerial review that would highlight the interrelations between population issues and global health.

11. The Bureau agreed with the proposals made by the Chairperson and noted that the theme of the 2009 annual ministerial review was closely linked to that of the

Commission in 2009, so that it would be straightforward to highlight how the work of the Commission and, in particular, the implementation of the Programme of Action of the International Conference on Population and Development, was helping to promote global health.

12. In view of the above, the Bureau noted that the procedure followed for representation of the Commission at the annual ministerial review in 2008 could be repeated in 2009, namely, that the Chairperson of the forty-second session of the Commission would represent the Commission at the 2009 annual ministerial review.

13. The Bureau requested the Chairperson to transmit to the Bureau of the Economic and Social Council, in writing, the suggestions listed in paragraph 10 above.

F. Special theme for the forty-fourth session of the Commission

14. The Bureau recalled the Commission's decision 2008/101, in which the Commission decided that the special theme for its forty-third session, in 2010, would be "Health, morbidity, mortality and development". The Bureau took note of the need to establish a multi-year work programme for the Commission and discussed various possible themes that might be considered in 2011. In doing so, the Bureau took into account the calendar of known events and activities in other relevant bodies of the United Nations, especially the General Assembly and the Economic and Social Council. The Bureau also considered the themes that the Commission had covered in the past. The Bureau noted that the theme of reproductive health had last been covered in 2002 and that focusing on that issue, in conjunction with fertility, in 2011 would be a valuable contribution to the preparation of the final review of the implementation of the Programme of Action of the International Conference on Population and Development in 2014 and to the review of the achievement of the Millennium Development Goals. The Bureau therefore recommended that the theme for the Commission's forty-fourth session in 2011 be "Fertility, reproductive health and development".

G. Resolutions and decisions

15. The Bureau recommended that the Commission consider adopting the following resolutions or decisions: (a) a decision on the draft agenda for the forty-third session; (b) a decision on the theme for its forty-fourth session in 2011; and (c) a resolution on the special theme of the forty-second session, namely, "The contribution of the Programme of Action of the International Conference on Population and Development to the internationally agreed development goals, including the Millennium Development Goals".

16. As for previous sessions, the Bureau recommended that a working group be established at the start of the resumed forty-second session of the Commission to discuss issues that might result in resolutions or decisions. The working group should begin its work on the afternoon of the first day of the resumed session of the Commission. The Bureau also recommended that the Chairperson of the Commission distribute initial drafts of resolutions and decisions to facilitate the deliberations of the working group. The Bureau further requested that the Chairperson's drafts be made available to members of the Commission and the

regional groups three weeks prior to the resumption of the forty-second session of the Commission.

H. Briefing for members of the Commission

17. The Bureau recommended that the Director of the Population Division organize, about a month prior to the resumption of the forty-second session of the Commission, a briefing for delegations on the status of documentation for the session, the organization of work and the resolutions and decisions likely to be considered by the Commission.

18. The Bureau stressed the importance of the timely availability of documents for the forty-second session in order to facilitate the preparation of statements by delegations. The Bureau endorsed the posting on the Internet of advanced unedited versions of those documents in English.

I. Conclusions and recommendations

19. The Bureau of the Commission on Population and Development met twice in New York on 21 October and 15 December 2008. The conclusions and recommendations resulting from those two meetings are summarized below.

20. The Bureau recommended the adoption of the draft organization of work for the forty-second session of the Commission.

21. The Bureau decided that three keynote speakers would be invited to address the Commission on the special theme, "The contribution of the Programme of Action of the International Conference on Population and Development to the internationally agreed development goals, including the Millennium Development Goals".

22. The Bureau decided to invite the President of the Economic and Social Council to address the Commission under item 6 of the draft agenda for its forty-second session.

23. The Bureau suggested that the Chairperson of the forty-second session of the Commission make a statement at the ministerial review to be conducted by the Economic and Social Council in 2009.

24. The Bureau recommended that the special theme for 2011 be "Fertility, reproductive health and development".

25. The Bureau recommended that a working group be established at the start of the resumed forty-second session of the Commission to discuss issues that might result in resolutions or decisions. The working group should begin its work on the afternoon of the first day of the resumed session of the Commission.

26. The Bureau recommended that the Commission consider adopting: (a) a decision on the agenda for the forty-third session; (b) a decision on the theme for the forty-fourth session in 2011; and (c) a resolution on the special theme of the forty-second session, namely, "The contribution of the Programme of Action of the International Conference on Population and Development to the

internationally agreed development goals, including the Millennium Development Goals”.

27. The Bureau requested that the Chairperson of the Commission distribute initial drafts of resolutions and decisions that might facilitate the deliberations of the working group. The Bureau requested that the Chairperson's drafts be made available to members of the Commission and to the regional groups at least three weeks prior to the resumption of the forty-second session of the Commission.

28. The Bureau recommended that the Director of the Population Division organize, a month prior to the resumption of the forty-second session of the Commission, a briefing for delegations on the status of documentation for the session, the organization of work and the resolutions and decisions likely to be considered by the Commission.



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Item 3 of the provisional agenda*

**Follow-up actions to the recommendations of the
International Conference on Population and Development**

World population monitoring, focusing on the contribution of the Programme of Action of the International Conference on Population and Development to the internationally agreed development goals, including the Millennium Development Goals

Report of the Secretary-General

Summary

In its decision 2007/1, the Commission on Population and Development decided that the special theme for its forty-second session would be the contribution of the Programme of Action of the International Conference on Population and Development to the internationally agreed development goals, including the Millennium Development Goals. The present report provides the basis for the Commission's deliberations.

The Programme of Action of the International Conference on Population and Development provides a comprehensive set of objectives and recommendations to improve human well-being and promote sustainable development and sustained economic growth. Its goals and objectives are consistent with other internationally agreed development goals and the actions it recommends fully support the attainment

* E/CN.9/2009/1.



of those goals. The core of the Programme of Action includes guidelines on policies, programmes and measures that are directly related to population dynamics and influence the growth and structure of populations. The report focuses on how the implementation of those core guidelines and the actions they entail contribute to the achievement of the internationally agreed development goals, including the Millennium Development Goals.

The report was prepared by the Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat.

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I. Introduction

1. The Programme of Action¹ of the International Conference on Population and Development provides a comprehensive set of objectives and recommendations to improve human well-being and promote sustainable development and sustained economic growth. Its goals and objectives are consistent with other internationally agreed development goals and the actions it recommends fully support the attainment of those goals, including the Millennium Development Goals.² The core of the Programme of Action includes guidelines on policies, programmes and measures that are directly related to population dynamics and influence the growth and structure of populations. The present report focuses on how those core guidelines and the actions they entail can contribute to the achievement of fundamental development goals.

2. Two of the major achievements of the twentieth century were the universal reduction of mortality and the ensuing reduction of fertility. In 1994, when the International Conference on Population and Development convened to consider the interrelations of population dynamics and sustainable development, there was no doubt that population growth was no longer the threat it had been when the first intergovernmental conference on population, the World Population Conference, had convened in 1974. In 1994, fertility had been declining for at least two decades in most countries of Asia and Latin America and the Caribbean and it was beginning to decline in several countries of sub-Saharan Africa. The annual population growth rate had dropped from its peak of 2.02 per cent in the years from 1965 to 1970 to 1.54 per cent and was definitely on the decline. A "population explosion" appeared to have been averted.

3. Today the global population growth rate is estimated to be even lower, at 1.17 per cent annually, and its continued decline is largely taken for granted. Yet, consideration of the population explosion that did not occur is instructive to underscore that there is still no time for complacency (see table 1). If fertility had remained constant in Asia at the level it had around 1970, its population in 2005 would have been 6.1 billion, close to the current population of the whole world. Because of the rapid reductions in fertility achieved by most countries in Asia, especially the most populous, the population of Asia in 2005 was instead 3.9 billion, 54 per cent lower than it would have been without a fertility decline. For Latin America and the Caribbean, the numbers are more moderate. Yet, without the rapid reduction in fertility it achieved, this major area would have had in 2005 a population 38 per cent larger than the one it actually achieved (769 million versus 558 million). The crucial finding is that, in the case of Africa, the difference in population between having had no reduction in fertility since 1970 (832 million) and that actually achieved (769 million) is very small, amounting to just 8 per cent of the current population. For the least developed countries, the difference is larger but also small, amounting to just 15 per cent of the 2005 population. These results imply that the population explosion was averted globally because fertility declined rapidly in Asia and Latin America and the Caribbean, but the explosion has largely played itself out in Africa and in most of the least developed countries. As the present report documents, rapid population growth is associated with a number of detrimental social and economic outcomes.

¹ *Report of the International Conference on Population and Development, Cairo, 5-13 September 1994* (United Nations publication, Sales No. E.95.XIII.18).

² See E/CN.9/2005/6, sect. III.

Table I
Population according to different scenarios by major area: 2005

	Medium variant	Constant fertility since 1970	Difference in 2005	Percentage difference
	(millions)			
Less developed regions	5 299	7 936	2 637	50
Least developed countries	767	882	115	15
Other less developed countries	4 532	7 054	2 522	56
Asia	3 938	6 079	2 141	54
Latin America and the Caribbean	558	769	211	38
Africa	769	832	62	8

4. The past four decades have shown that government policy and commitment can make an important difference in shaping population dynamics. The successes achieved would not be a reality without government commitment or the continuous engagement of the international community, as crystallized in the Programme of Action of the International Conference on Population and Development. Critical to the success of the Programme of Action is its emphasis on action based on fundamental rights and principles. Recognizing that respect for human rights underpins the attainment of development, the Programme of Action sets objectives and provides recommendations that are justifiable not only because they lead to development or have positive impacts on people's well-being, but also because they are an expression of the rights of the individual. Thus, the measures to advance gender equality and equity and the empowerment of women that the Programme of Action champions are as much a matter of rights as of development. Full implementation of the Programme of Action is all the more urgent today because the time to reach its objectives is running short and, as the present report documents, gaps in implementation are particularly common in low-income countries and among the poorer segments of society. Accelerating the implementation of the Programme of Action would not only contribute to achieving the internationally agreed development goals but would also ensure that all people enjoy fully their human rights.

II. Eradicating extreme poverty and hunger

A. Eradicating extreme poverty

5. The eradication of extreme poverty is a crucial development goal. To achieve the target of reducing by half the proportion of people living on less than \$1 a day by 2015, policies that address directly the economic and social issues causing or perpetuating poverty are necessary. Yet, population policy can also make a major contribution to the eradication of poverty because population dynamics, economic change and social well-being are closely interlinked. Rapid population growth imposes increasing demands on existing resources and is associated with lower incomes. Thus, in 2005, the least developed countries had the lowest average per capita income and the fastest rate of population growth among development groups

(see table 2). In comparison, per capita income in the rest of the developing countries was four times as high and their population growth rate was half that of the least developed countries but had been declining rapidly since the 1970s. Developed countries as a group had the highest income per capita and a very low rate of population growth. Because most least developed countries are in Africa, the continent also had a low per capita income in 2005 and rapid population growth.

Table 2
Annual population growth rate, total fertility and GDP per capita by major area, 1995 and 2005

Major area	Population growth rate (percentage)		Total fertility (children per woman)		GDP per capita (USD, PPP)	
	1990-1995	2005-2010	1990-1995	2005-2010	1990	2005
More developed regions	.045	0.28	1.68	1.60	17 159	28 296
Less developed regions	1.83	1.37	3.42	2.75	2 119	5 181
Least developed countries	2.69	2.37	5.68	4.63	1 115	1 421
Other less developed countries	1.70	1.19	3.11	2.45	2 214	5 582
Africa	2.61	2.25	5.69	4.67	1 705	2 503
Asia	1.63	1.13	2.97	2.34	3 274	6 197
Latin America and the Caribbean	1.71	1.24	3.03	2.37	7 485	8 333
North America	1.08	0.25	1.99	2.00	23 268	40 631
Europe	0.20	-0.02	1.58	1.45	14 042	21 998
Oceania	1.62	1.21	2.48	2.30	23 310	25 296

Sources: United Nations Data Online (UNdata), accessed on 21 October 2008, and *World*

Population Prospects: The 2006 Revision (United Nations publication, Sales No. E.07.XIII.2).

Abbreviations: GDP=gross domestic product, PPP=purchasing power parities, USD=United States dollars.

6. The majority of developing countries, which experienced rapid population growth after 1950 when mortality decreased long before their fertility began to decline, are grappling today with the challenge of providing decent employment for their rapidly growing populations of working age. In 2008, about 200 million persons were unemployed, an 18 per cent increase over 1995 levels.³ The Programme of Action recognized that high population growth, generated by the lag between the decline in mortality and that in fertility, would increase the challenges faced by Governments in generating productive employment (para. 3.15).

7. The decline in fertility that is part of the demographic transition can increase national savings and economic growth by reducing the proportion of dependent children and increasing that of persons of working age, thus producing a "demographic dividend".⁴ The decreasing dependency ratios that arise when fertility

³ International Labour Organization, *Global Employment Trends* (Geneva, International Labour Office, 2008).

⁴ Andrew Mason and Sang-Hyop Lee, "The demographic dividend and poverty reduction" in *Proceedings of the Seminar on the Relevance of Population Aspects for the Achievement of the Millennium Development Goals*, United Nations, New York, 17-19 November 2004.

decreases have contributed to the rise in per capita income and economic growth in countries as diverse as China, Egypt, Ireland, Japan, Sweden or the United States of America.⁵ The medium-term effects of fertility reductions on economic growth in both developed and developing countries account for about 20 per cent of per capita output growth between 1960 and 1995.⁶

8. The newly industrializing countries of Eastern and South-Eastern Asia, in particular, experienced very fast fertility reductions after 1965 and have benefited from vigorous economic growth.⁷ Major public investments in education coupled with a stable macroeconomic environment, economic growth that focused on job creation and institutions that promoted savings have been critical in allowing those countries to derive the full benefits associated with the demographic dividend. During the 1980s, about a third of the increase in per capita income in the newly industrializing countries of Eastern and South-Eastern Asia was due to the demographic dividend.⁸ In contrast, economic growth has fallen short of its full potential in most countries in Latin America and the Caribbean that also experienced fast fertility declines.⁹ These examples show that, although reductions in fertility can potentially accelerate economic growth, the realization of that potential depends on developing the right institutions and adopting appropriate economic and social policies, including measures to build human capital, generate jobs and improve income distribution.

9. Faster and sustained economic growth provides Governments with more leeway to combat poverty. High levels of poverty are associated with the persistence of high fertility. In 2005, developing countries with at least 40 per cent of their population living on less than \$1 a day had an average fertility of 5.4 children per woman, more than double that of developing countries with poverty levels below 10 per cent (see table 3). The group of poorest countries also had a high population growth rate (2.5 per cent), more than triple that of countries with low poverty levels (0.7 per cent per year). The four poorest countries — Burundi, Liberia, Rwanda and the United Republic of Tanzania — each with a poverty level surpassing 75 per cent, also had a total fertility surpassing 6 children per woman and population growth rates surpassing 2.5 per cent.

⁵ David E. Bloom and David Canning, "Global demographic change: dimensions and economic significance", *Population and Development Review*, supplement to vol. 34, 2008; Bo Malmberg and Thomas Lindh, "Demographically based global income forecasts up to the year 2050", *International Journal of Forecasting*, vol. 23, No. 4, 2007.

⁶ Allen Kelley and Robert Schmidt, "Evolution of recent economic-demographic modelling: A synthesis", *Journal of Population Economics*, vol. 18, No. 2, June 2005.

⁷ Andrew Mason, editor, *Population Change and Economic Development in East Asia: Challenges Met, Opportunities Seized* (Stanford University Press, 2001); David E. Bloom, David Canning and Jaypee Sevilla, *The Demographic Dividend: A New Perspective on the Economic Consequences of Population Change* (Santa Monica, California, Rand Press, 2002).

⁸ David E. Bloom and Jeffrey G. Williamson, "Demographic transitions and economic miracles in emerging Asia", *World Bank Economic Review*, vol. 12, No. 3, 1998.

⁹ Andrew Mason, "Demographic transition and demographic dividends in developed and developing countries", in: *Proceedings of the United Nations Expert Group Meeting on Social and Economic Implications of Changing Population Age Structures*, Mexico City, 31 August–2 September 2005; Casio Turra and Bernardo Queiroz, "Intergenerational transfers and socio-economic inequality in Brazil: a first look", *Notas de Población*, No. 80, October 2005.

Table 3
Population growth rate and total fertility in 2000-2005 for developing countries by poverty level in 2005

	Percentage of people living on less than \$1 a day around 2005 ^a			
	Under 10	10 to 19.9	20 to 39.9	40 or over
Number of countries	44	13	23	33
Annual population growth rate (percentage)	0.7	1.3	1.9	2.5
Total fertility	2.1	3.2	3.8	5.4

Sources: The World Bank online Poverty Analysis Tool (*PovcalNet*), accessed on 14 October 2008; *World Population Prospects: The 2006 Revision* (United Nations publication, Sales No. E.07.XIII.2).

^a The reference date varies by country, ranging from 1995 to 2007. For 102 of the 113 countries considered, the estimate refers to 2000 or later.

10. Analyses of the impact of declining fertility on poverty reduction have shown that demographic change alone accounted for a 14 per cent drop in poverty levels in the developing world during 1960-2000 and could produce an additional 14 per cent reduction during 2000-2015 if fertility decline accelerates in high-fertility countries.⁴

11. High fertility is associated with the persistence of poverty within countries because low-income groups generally have much higher fertility than high-income groups. Surveys in 56 developing countries showed that women in the lowest wealth quintile had, on average, two children more than women in the upper quintile.¹⁰ In Africa, the difference was higher, at 2.8 children, and it was highest in Latin America and the Caribbean, where it amounted to 3.8 children. Similar differences exist when the education of women is the discriminating factor, because educational attainment and wealth are highly correlated. Data on 43 developing countries for the late 1990s indicate that women with no schooling had, on average, 2.3 children more than women with at least a secondary education.¹¹

12. Consequently, reducing fertility among poor households can contribute to reducing poverty, both directly and indirectly. The higher the natural increase of the population living in poverty, the more rapidly its share of the population will rise, therefore increasing the overall poverty level. The higher rate of natural increase of those living on less than \$1 a day puts an upward pressure on poverty levels, equivalent to between 10 per cent and 50 per cent of the rate of poverty reduction in the developing world between 1990 and 2001.¹² This impact is largest in Africa and Southern Asia.

¹⁰ Davidson R. Gwatkin, Shea Rutstein, Kiersten Johnson, Eldaw Suliman, Adam Wagstaff, and Agbessi Amouzou, *Socio-Economic Differences in Health, Nutrition and Population within Developing Countries: An Overview* (Washington, D.C., The World Bank, 2007).

¹¹ Shea Oscar Rutstein, *Fertility Levels, Trends and Differentials 1995-1999*. DHS Comparative Reports No. 3 (Calverton, Maryland, ORC Macro, December 2002).

¹² Martin Ravallion, "On the contribution of demographic change to aggregate poverty measures for the developing world", *World Bank Policy Research Working Paper*, No. 3580, The World Bank, April 2005.

13. High fertility among the poor can contribute to the intergenerational reproduction of poverty. The more children a household has, the fewer resources will be available for each and the less likely that children may get an adequate education. By having fewer children, poor households would be able to invest more on the nutrition, health and education of each child. When poor households are unable to realize their reproductive goals because they lack access to family planning, policies to improve such access are a useful adjunct to other policies aimed at reducing poverty.

14. Generally, the Governments of countries experiencing high population growth are concerned about the implications of that growth.¹³ Thus, among the 11 countries whose populations were growing at 3 per cent or more annually during 2005-2010, 9 — Benin, Burundi, Eritrea, Jordan, Liberia, Mali, the Niger, Timor-Leste and Uganda — viewed their population growth rates as too high and all but Timor-Leste had adopted policies to reduce population growth. The other two, Afghanistan and the Democratic Republic of the Congo, considered their growth rates satisfactory and had no policies to influence them. Among the 36 countries with annual growth rates ranging from 2.0 to 3.0 per cent, 72 per cent considered them as too high and 67 per cent had adopted policies to lower them. Even among the 66 countries with more moderate growth rates, ranging from 1.0 to 2.0 per cent, 48 per cent considered them to be too high and most of these had adopted policies to lower them. In addition, among the 82 countries whose growth rates were below 1.0 per cent annually, just 32 per cent reported intervening to increase population growth.

B. Eradicating hunger

15. Poverty and hunger are closely intertwined because, although there is enough food to feed the 6.8 billion people on Earth, poor people are priced out of the food market, all the more so because, after years of relative stability, the prices of major staple foods rose sharply between 2006 and the first half of 2008.¹⁴ Consequently, the number of undernourished people is reckoned to have increased by 40 million in 2008 alone, to reach 963 million, up from 923 million in 2007 and 848 million in 2003-2005,¹⁵ making it more difficult to reach the target of halving by 2015 the proportion of people who suffer from hunger (Millennium Development Goal 1). Although food prices have been declining recently, the food crisis of 2008 made evident the vulnerabilities of many populations. The crisis resulted from increases in the demand for food that were not matched by increases in food supplies. Rising demand stems from population growth as well as from rising incomes and changing dietary patterns in developing countries, particularly in China. The slowing growth

¹³ *World Population Policies 2007* (United Nations publication, Sales No. E.08.XIII.8).

¹⁴ Between January 2006 and March 2008 world food prices soared 68 per cent. Wheat prices doubled between April 2007 and March 2008, while rice prices tripled between January and April 2008 as reported in Quentin Wodon and Hassan Zaman, "Rising food prices in sub-Saharan Africa: Poverty impact and policy responses", *World Bank Policy Research Working Paper*, No. 4738, 2008.

¹⁵ Food and Agriculture Organization (FAO), *The State of Food Insecurity in the World 2008*, <http://www.fao.org/docrep/011/i0291e/i0291e00.htm> accessed on 20 December 2008; FAO, Committee on World Food Security, *Assessment of the World Food Security and Nutrition Situation*, thirty-fourth session, 14-17 October 2008.

of the food supply is due to many factors, including recent increases in the cost of seeds and fertilizer as energy prices soared, long-term underinvestment in rural infrastructure and agricultural development in many developing countries, growing constraints in access to land and water, and the reallocation of land to the production of biofuels.¹⁶

16. Globally, population growth is a major determinant of the demand for food. According to FAO, calorie intake is expected to increase from a world average of 2,803 kcal per person per day in 1999 to 3,050 by 2030,¹⁷ a 9 per cent increase per person. During that period the world population is projected to rise from 6.0 billion to 8.3 billion, leading to a global increase of nearly 50 per cent in the caloric demand, 76 per cent of which is attributable to increases in the number of people.

17. At the country level, higher natural increase among the poor can contribute to increase the levels of hunger and undernutrition just as it can contribute to increase poverty levels. Because low-income households tend to have higher fertility than those with higher incomes, they usually have to allocate a higher proportion of their incomes to food and are particularly vulnerable to rising food prices or costs of food production. Thus, higher food prices have had more serious impacts on developing countries whose populations are growing rapidly and where poverty was high before the crisis. Between 2005 and 2007, rising food prices have increased poverty levels by about 4.5 percentage points in low-income countries, implying that an additional 105 million people have fallen into poverty.¹⁸

18. Rising food prices have resulted in 41 million additional undernourished people in Asia and 24 million in sub-Saharan Africa between 2003-2005 and 2007, the two regions that in 2003-2005 accounted for 89 per cent (750 million) of the hungry people in the world.¹⁹ Increases in undernutrition, though smaller in magnitude, occurred in all other developing regions and in Latin America they erased all progress made since 1995. Clearly, policies to address the effects of food price shocks should give priority to the immediate protection of the most vulnerable households and individuals, including women and children, in order to achieve Millennium Development Goal 1. But longer-term responses need to take account of how population policies can be part of a coordinated response to promote sustainable livelihoods and buttress development prospects for all by helping households to avoid poverty traps.

III. Achieving universal education

19. Achieving universal primary education by 2015 and extending education for all, boys and girls, at the secondary and higher levels are goals established by the Programme of Action (paras. 11.6, 11.8, and 4.18), objectives echoed by the

¹⁶ Joachim von Braun and others, "High food prices: The what, who, and how of proposed policy actions", *International Food Policy Research Institute Policy Brief*, May 2008, <http://www.ifpri.org/PUBS/ib/FoodPricesPolicyAction.pdf>.

¹⁷ *World Agriculture: Towards 2015/2030, Summary Report* (Rome, FAO, 2002).

¹⁸ Maros Ivanic and Will Martin "Implications of higher global food prices for poverty in low-income countries", *World Bank Policy Research Working Paper No. 4594*, 2008.

¹⁹ FAO, Committee on World Food Security, *Assessment of the World Food Security and Nutrition Situation*, thirty-fourth session, 14-17 October 2008.

Millennium Development Goals. Much progress has been made towards achieving universal primary education (Millennium Development Goal 2). In 2006, primary school enrolment in developing countries reached 88 per cent. Nevertheless, inequalities in access to education, related in part to family size, continue to pose challenges for the achievement of that goal. At both the household and the country levels, investment in the education of children is less likely to be sufficient when the number of children is large. Sustained high fertility results in rapidly increasing numbers of school-age children, which translate into increasing demands on education systems and families.

20. Countries with the worse education indicators tend to have high proportions of children and high population growth rates. Thus, in the 29 countries with net enrolment ratios in primary school below 80 per cent, children under age 15 accounted for 42 per cent of the population in 2005 and the population growth rate averaged 2.3 per cent annually (see table 4). Similarly, in the 19 countries where over 20 per cent of persons aged 15-24 were illiterate in 2006, children accounted for 42 per cent of the population and the growth rate averaged 2.4 per cent. In contrast, the 47 countries with net enrolment ratios in primary school above 95 per cent and the 74 countries with low percentages of illiterate youth (below 5 per cent) had lower proportions of children (25 per cent of the population) and population growth rates averaging less than 1 per cent annually, yet another indication that slower population growth makes it easier to invest in education.

Table 4

Population growth rate in 2000-2005 and percentage of the population under age 15 in 2005 by selected education indicators

	Percentage of youth who can read and write			Net enrolment ratio in primary education (percentage)		
	Below 80	Between 80 and 95	Above 95	Below 80	Between 80 and 95	Above 95
Number of countries	19	23	74	29	63	47
Annual population growth rate (percentage)	2.4	1.9	0.9	2.3	1.0	0.8
Percentage of the population under 15	41.5	38.5	25.9	41.5	27.7	23.6

Sources: UNESCO Institute for Statistics, Online Data Centre (<http://stats.uis.unesco.org>), accessed on 7 October 2008; *World Population Prospects: The 2006 Revision* (United Nations publication, Sales No. E.07.XIII.2).

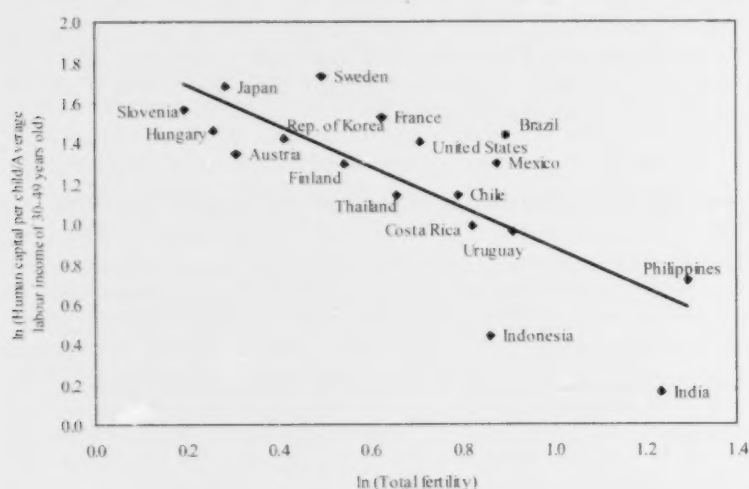
21. Intergenerational transfer accounts indicate that countries with lower fertility spend substantially more in the health and education of children than countries with higher fertility (see figure 1). On average, countries with a total fertility of 3.0 children per woman spend about one third as much per child relative to labour income as a country with a total fertility of 1.0 child per woman.²⁰ Studies at the household level show that, on average, children born into large families have fewer

²⁰ Ronald Lee and Andrew Mason, "Fertility, human capital and economic growth over the demographic transition", National Transfer Accounts Working Paper WP08-02, 2008.

opportunities to receive schooling than children born into small families, especially in countries where most education costs are borne by parents.²¹

22. The level of education of women is a key determinant of fertility behaviour: women with higher education are more likely to use contraception and to have fewer children than women with fewer years of schooling. The maintenance of high fertility among poorer women generates a vicious circle whereby their children, particularly girls, are less likely to receive schooling and are more likely to have high numbers of children themselves. The Programme of Action makes a strong case for the achievement of education for all to ensure that the mutually reinforcing effects of increased education and smaller families can benefit development (chap. XI).

Figure I
Spending on education per child against total fertility, selected countries



Source: Derived from National Transfer Account data posted at <http://www.ntaccounts.org>

IV. Population and the goals related to health

23. The health of a population is an important determinant of economic growth. Empirical studies²² show that health improvements provide a significant boost to economic growth in developing countries, implying that health, like education, is a fundamental component of human capital. Better health leads to higher income and vice versa, generating a beneficial feedback whereby improvements in health and rising incomes are mutually reinforcing. The Programme of Action recognizes this

²¹ Cynthia Lloyd, "Investing in the next generation: the implications of high fertility at the level of the family", *Population and Development: Old Debates and New Conclusions* (New Brunswick, New Jersey: Transaction Publishers, 2004), pp. 181-202; Claudia Buchmann and Emily Hannum, "Education and stratification in developing countries: A review of theories and research", *Annual Review of Sociology*, vol. 27, 2001, pp. 77-102.

²² Guillem López-Casasnovas and others, *Health and Economic Growth: Findings and Policy Implications* (Boston, Massachusetts, MIT Press, 2005); David E. Bloom and David Canning, "The health and wealth of nations", *Science*, vol. 287, No. 5456, 18 February 2000.

reality by setting ambitious objectives for the improvement of health. Underscoring the increase in longevity since 1950 as a major achievement, it calls for further increases in the healthy life-span and a reduction of disparities in life expectancy between and within countries (para. 8.3(b)) and sets the goal of increasing life expectancy to at least 75 years by 2015 or to at least 70 years in countries with high mortality in 1994 (para. 8.5).

A. Reducing child mortality

24. The Programme of Action calls for a reduction of under-five mortality to below 45 deaths per 1,000 live births in 2015 (para. 8.16), a goal that is more ambitious than the target under Millennium Development Goal 4 (two-thirds reduction between 1990 and 2015). Although child mortality in developing countries has been decreasing, passing from 103 to 74 deaths per 1,000 births between 1990 and 2007, its rate of decline would need to increase more than fivefold to reach the Millennium Development Goal 4 target by 2015 (see table 5). Sub-Saharan Africa, has seen its under-five mortality decline at a sluggish pace, which would need an eightfold increase to reach the established target.

Table 5

Under-five mortality by development group and sub-Saharan Africa, 1990, 2007 and 2015

Development group	Under-five mortality (deaths per 1,000 births)			Annual rate of decline (percentage)	
	1990	2007	2015	Observed 1990-2007	Required 2008-2015
World	93	68	31	1.8	9.8
Developing countries	103	74	34	1.9	9.6
Least developed countries	179	130	60	1.9	9.7
Sub-Saharan Africa	186	148	62	1.3	10.9

Source: *The State of the World's Children 2009* (New York, United Nations Children's Fund, 2008).

Note: Sub-Saharan Africa excludes the Sudan.

25. To reduce child mortality, the Programme of Action calls for the strengthening of primary health systems to provide prenatal and neonatal care and delivery assistance and for the promotion of exclusive breastfeeding of young infants, the provision of micronutrient supplementation and immunization against tetanus. It stresses the importance of combating major childhood diseases, particularly infectious and parasitic diseases, and preventing child malnutrition, especially among girls. The key actions²³ for its further implementation emphasize the need to expand immunization and the importance of using oral rehydration therapy in treating diarrhoea.

26. A review of health interventions in 68 countries, accounting for 97 per cent of all child deaths, found major progress in expanding coverage of interventions

²³ See General Assembly resolution S-21/2, annex.

provided through scheduled delivery, such as immunizations, vitamin-A supplementation and insecticide-treated bed-nets.²⁴ Less progress was found in strengthening health systems and, consequently, interventions requiring well-functioning clinical services, including the management of illnesses in newborn and older children, are still far from satisfying demand. Furthermore, combating malnutrition remains a major challenge: in 62 of the 68 countries considered, at least a fifth of all children under age 5 were stunted (i.e., they had a low height for their age because of chronic undernutrition).

27. Inadequate access to family planning is a further impediment to increasing child survival. Closely spaced births and pregnancies in adolescent and older women put children at increased risk of death. Defining children at high risk as those born to mothers under age 18 or older than 34, those born within 24 months of a preceding birth and those having a birth order of 4 or higher, the proportion of children at high risk is highly correlated with the level of under-five mortality, as data derived from 172 Demographic and Health Surveys conducted during 1985-2007 show (see figure II). Without controlling for other variables, the proportion of births in high-risk categories accounts for 41 per cent of the intercountry variation in under-five mortality. To the extent that women have children early or late in their reproductive lives or too closely spaced because they lack access to family planning, improving that access would reduce the risk of dying in childhood.

28. The inter-pregnancy interval is the time between a live birth or another pregnancy outcome and the start of the next pregnancy. Inter-pregnancy intervals longer than two years reduce child mortality. Analysis of the survivorship of over a million births recorded in Demographic and Health Surveys between 2000 and 2005 found that inter-pregnancy intervals ranging from 36 to 47 months were associated with the lowest risk of death in childhood.²⁵ If women waited at least 24 months after a live birth before conceiving again, under-five mortality would fall by 13 per cent, and it would drop by 25 per cent if women waited 36 months. Accordingly, WHO has issued new guidelines advising women to wait at least 24 months after a live birth before trying to conceive again.²⁶

29. Governments of developing countries are particularly concerned about their high infant and child mortality: more than 80 per cent consider their levels unacceptable. Countries with high and increasing numbers of births face greater challenges in improving child health. Efforts to satisfy the unmet need for family planning can reduce significantly the costs of ensuring child health. In Ghana, for instance, satisfying the unmet need could reduce by 1.4 million the number of measles immunizations required between 2006 and 2015.²⁷ In order to accelerate the reduction of child mortality, particularly in low-income countries with high fertility,

²⁴ Countdown Coverage Writing Group. "Countdown to 2015 for maternal, newborn, and child survival: the 2008 report on tracking coverage of interventions", *The Lancet*, vol. 371 (2008).

²⁵ Shea Oscar Rutstein, "Further evidence of the effects of preceding birth intervals on neonatal, infant, and under-five-years mortality and nutritional status in developing countries: evidence from the Demographic and Health Surveys". *DHS Working Papers*, No. 41 (Calverton, Maryland, Macro International Inc., 2008).

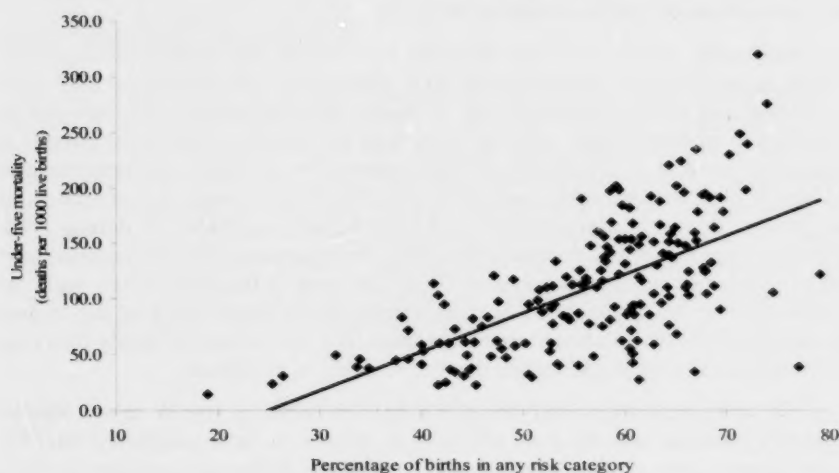
²⁶ World Health Organization, *Report of a WHO technical consultation on birth spacing* (Geneva: World Health Organization, 2006).

²⁷ Scott Moreland and Sandra Talbird, *Achieving the Millennium Development Goals: The contribution of fulfilling the unmet need for family planning* (Washington, D.C., United States Agency for International Development, 2006).

expanded access to family planning combined with reinvigorated efforts to expand interventions that improve child health is crucial to ensure the achievement of Millennium Development Goal 4.

Figure II

Under-five mortality versus percentage of births in risk categories, 1985-2007



Source: MEASURE DHS STATcompiler, <http://www.measuredhs.com>, accessed on 14 October 2008.

B. Combating malaria

30. Malaria causes 250 million episodes of illness annually and 900,000 deaths. Efforts are under way to achieve universal coverage of appropriate interventions by 2010, including the distribution of an estimated 720 million bednets treated with long-lasting insecticides,²⁸ intermittent residual spraying for vector control and intermittent preventive treatment of pregnant women in high-transmission areas to reduce the prevalence of malaria-related anaemia among them and the ensuing low birth weight of their children. Although the distribution of bednets has expanded rapidly, surveys conducted around 2006 in 18 African countries show that just 23 per cent of children and 27 per cent of pregnant women slept under bednets.²⁹

31. Currently, only 18 per cent of pregnant women in high-transmission areas receive intermittent preventive treatment. To achieve universal coverage, 25 million pregnant women in Africa would require treatment annually. Initiatives to prevent or treat malaria during pregnancy work best when cooperation between national malaria control programmes and reproductive health programmes is close and when treatment against malaria is part of a comprehensive package of antenatal care. Since in several African countries much higher numbers of pregnant women receive antenatal care than get intermittent treatment, visits to antenatal care centres can be

²⁸ *The Global Malaria Action Plan* (Geneva, Roll Back Malaria Partnership, 2008).

²⁹ World Health Organization, *World Malaria Report 2008* (Geneva, Sales No. WHO/HTM/GMP/2008.1).

used to expand antimalarial treatment and distribute bednets. Ultimately, scaling up malaria control and prevention efforts requires expanding and improving health systems to support other interventions.

32. Reducing population growth through improved access to family planning can reduce the cost of malaria control. The costs of providing and maintaining bednets in 16 African countries could be reduced by between 4 and 19 per cent during 2005-2015 if the unmet need for family planning were satisfied.²⁷

C. Controlling the HIV/AIDS epidemic

33. The Programme of Action was one of the first internationally agreed documents calling for concerted efforts to prevent the expansion of the HIV/AIDS epidemic and to support those affected by the disease (para. 8.29b). Despite major progress made in developing effective treatments for the disease, the epidemic remains one of the greatest challenges confronting the international community. Thus, the Governments of 81 per cent of developed countries and 93 per cent of developing countries consider HIV/AIDS a major concern. A multipronged strategy is being pursued to control the epidemic, focusing on prevention, care and treatment. Key elements of the strategy are the protection from discrimination and stigmatization of persons living with HIV, the establishment of HIV/AIDS coordination bodies at the national level, the development of multisectoral strategies, and the building of partnerships with civil society, including people living with HIV.

34. In 2008, 33 million people were living with HIV but trend estimates show encouraging signs of progress. Globally, the percentage of adults living with HIV levelled off as of 2000 and the number of new HIV infections has fallen in several countries. In 14 of 17 African countries with adequate survey data, the percentage of pregnant women aged 15-24 who are living with HIV has been declining since 2000-2001 and, in 7 countries, the drop in infections among women aged 15-24 has equalled or exceeded the 25 per cent reduction called for by the Declaration of Commitment on HIV/AIDS.³⁰

35. The key actions for the further implementation of the Programme of Action²³ underscored in paragraph 68 the potential synergies between HIV prevention and reproductive health by calling on Governments to "ensure that prevention of and services for sexually transmitted diseases and HIV/AIDS are an integral component of reproductive and sexual health programmes at the primary health-care level". Most women in developing countries first establish contact with the health system when they seek antenatal care or family planning services. This contact provides a valuable opportunity to provide women with information and counselling on how to prevent HIV infection. Because the prevention of mother-to-child transmission of HIV is a priority, antenatal care should incorporate voluntary testing and counselling services to identify the women that need treatment and should include means of channelling HIV-positive women and their families to services that provide care, treatment and support. Although significant progress has been made in expanding the treatment of HIV-positive pregnant women to prevent mother-to-child

³⁰ Joint United Nations Programme on HIV/AIDS (UNAIDS), *Report on the Global HIV/AIDS Epidemic 2008* (Geneva, 2008).

transmission of HIV, in 2007 only 33 per cent of those women were receiving the necessary antiretroviral treatment. In a study of 51 countries affected by the epidemic, only 8 — Benin, Botswana, Brazil, Burkina Faso, Kenya, Rwanda, South Africa and Swaziland — were considered on track to achieve 80 per cent coverage of HIV-positive pregnant women by 2010,²⁴ as called for by the General Assembly at its special session on HIV/AIDS in 2001.

36. Because there is a high degree of overlap between the population at risk of unintended pregnancies and those at risk of exposure to HIV, family planning programmes can contribute to reduce the risk of infection. In addition, when women are already HIV-positive, family planning can enable them to avoid unwanted pregnancies. An analysis of the impact of family planning in preventing unwanted pregnancies among HIV-positive women concluded that it is a more cost-effective means of reducing HIV prevalence among children than provision of antiretroviral therapy to HIV-positive pregnant women.³¹

37. Expansion of antiretroviral treatment has been fast, yet in 2007, only 3 million of the 9.7 million people in developing countries who needed treatment received it. Moreover, much remains to be done to prevent the spread of HIV. In countries having conducted the necessary surveys, at most 40 per cent of men and 36 per cent of women aged 15-24 understood how HIV is transmitted and how to prevent infection, levels well below the 95 per cent target. Furthermore, groups especially vulnerable to infection continue to lack adequate access to HIV-prevention services.

D. Reducing maternal mortality

38. The Programme of Action calls for countries to reduce maternal mortality by half between 1990 and 2000 and by a further half by 2015 (para. 8.21), implying an overall reduction of 75 per cent between 1990 and 2015, as established under Millennium Development Goal 5. To achieve this goal a multipronged strategy is necessary. A woman's lifetime probability of surviving the reproductive years can be increased by reducing the number of pregnancies she has. Measures to reduce the risk of complications during pregnancy and delivery should be taken and access to adequate obstetric care must be improved to ensure that, if complications arise, the risk of dying during delivery is minimized. In addition, providing trained health assistance to manage the complications of abortion and offering post-abortion counselling, education and family planning in order to prevent repeated abortions are also required. Lastly, delaying marriage and preventing pregnancy among very young women reduce their risk of maternal death, as do strategies to prevent their exposure to HIV.

39. Reliable data to assess levels and trends in maternal mortality are lacking, particularly in developing countries where maternal mortality is high. It is estimated that 536,000 women died in 2005 because of maternal causes, 99 per cent of whom died in developing countries.³² In 14 countries, mostly in sub-Saharan Africa, maternal mortality was higher than 1,000 deaths per 100,000 live births. Whereas average maternal mortality in the less developed regions was estimated at

³¹ Heidi W. Reynolds and others, "The value of contraception to prevent perinatal HIV transmission", *Sexually Transmitted Diseases*, vol. 33, No. 6, 2006.

³² *Maternal mortality in 2005: estimates developed by WHO, UNICEF, UNFPA and the World Bank* (Geneva, World Health Organization, 2007).

450 deaths per 100,000 births in 2005, that in the more developed regions was 11 (table 6). Africa had the highest maternal mortality, at 820 deaths per 100,000 births.

Table 6
Maternal mortality by major area, 1990 and 2005

Major area	Maternal mortality (deaths per 100,000 live births)		Average annual rate of reduction (percentage)	
	1990	2005	Observed 1990-2005	Required 2005-2015
World	430	400	0.5	13.1
More developed regions	17	11	2.9	9.5
Less developed regions	480	450	0.4	13.2
Least developed countries	900	870	0.2	13.5
Other less developed countries	380	310	1.4	11.8
Africa	830	820	0.1	13.7
Asia	400	320	1.5	11.6
Europe	23	13	3.8	8.2
Latin America and the Caribbean	180	130	2.2	10.6
North America	8	10	-1.5	16.1
Oceania	210	180	1.0	12.3

Source: *Maternal mortality in 2005* (World Health Organization, Geneva, 2007).

Note: Estimates for 1990 and 2005 are based on the same methodology. Rates of reduction have been calculated from those estimates.

40. Little progress has been made in reducing maternal mortality in developing countries. Between 1990 and 2005, maternal mortality in less developed regions declined by 0.4 per cent annually, far below the 13 per cent annual decline required to achieve Millennium Development Goal 5. In Africa, maternal mortality has remained virtually unchanged. Even in Latin America and the Caribbean, where maternal mortality has declined by 2.2 per cent annually, this rate falls far short from the 10.6 per cent needed to attain Millennium Development Goal 5. A major reason for these slow declines is that prevention of maternal mortality demands well-functioning health systems, able to provide care during the antenatal period, at delivery and during the post-partum and able to ensure access to emergency obstetric interventions when complications arise. While health systems improve, increasing access to skilled birth attendants is a crucial first step in preventing maternal deaths.³³

41. Because the lifetime risk of maternal mortality depends on the number of pregnancies a woman has, access to family planning that allows women to avoid mistimed or unwanted pregnancies can reduce maternal mortality.³⁴ Thus, between

³³ Jon Rohde and others, "30 years after Alma-Ata: has primary health care worked in countries?" *The Lancet*, vol. 372, 2008.

³⁴ Stan Bernstein and Charlotte Juul Hansen, *Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals* (New York, United Nations Development Programme, 2006).

25 and 40 per cent of maternal deaths could be eliminated if unplanned and unwanted pregnancies were prevented.³⁵ Nearly 52 million unintended pregnancies could be averted annually if the unmet need for family planning were satisfied, resulting in the prevention of 142,000 maternal deaths.³⁶ In addition, by preventing unwanted pregnancies via contraception, fewer women would resort to abortion under unsafe conditions. Unsafe abortion causes about 13 per cent of maternal deaths annually and nearly all those deaths are preventable.³⁷

42. With fewer pregnancies, the costs of providing safe motherhood services to those giving birth would be lower. In 16 African countries, success in preventing unplanned or unwanted pregnancies could produce savings ranging from 4 to 21 per cent of the cumulative costs of implementing a safe motherhood programme between 2005 and 2015.²⁷ Furthermore, the savings on maternal care would generally surpass the costs of expanding family planning programmes.

E. Ensuring reproductive health

43. At the 2005 World Summit, heads of State and Government committed themselves to achieving universal access to reproductive health by 2015, recognizing that it could contribute to reducing maternal mortality, improving maternal health, reducing child mortality, promoting gender equality, combating HIV/AIDS and eradicating poverty. The Programme of Action defines reproductive health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition is the right of men and women to be informed and have access to safe, effective, affordable and acceptable methods of family planning (para. 7.2).

44. Globally, the percentage of women aged 15-49, married or in union and using contraception increased from 56 per cent in 1993 to 63 per cent in 2003, implying that 716 million women were using contraception in 2003. Contraceptive prevalence is high in almost all major areas: 73 per cent in Northern America, 71 per cent in Latin America and the Caribbean, 68 per cent in Asia and Europe, and 60 per cent in Northern Africa (excluding the Sudan). However, very low levels characterize sub-Saharan Africa (22 per cent) and the developing regions of Oceania (27 per cent). Sub-Saharan Africa, in particular, has failed to reach the contraceptive levels projected in 1994 (31 per cent), which guided the funding recommendations in the Programme of Action. Furthermore, in 60 per cent of the 47 countries in sub-Saharan Africa having the required data, contraceptive prevalence remains below 25 per cent. Contraceptive prevalence is especially low in Eastern Africa, Middle Africa and Western Africa, where fertility remains well above 5 children per woman (see figure III). Indeed, contraceptive prevalence is highly correlated

³⁵ Oona M. R. Campbell and Wendy J. Graham, "Strategies for reducing maternal mortality: getting on with what works", *The Lancet*, vol. 368, 2006.

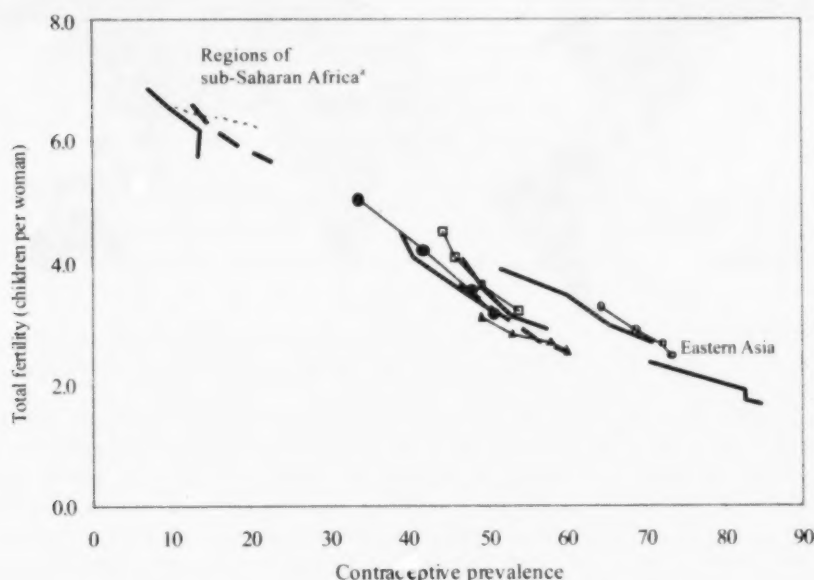
³⁶ Michael Vlassoff and others, "Assessing costs and benefits of sexual and reproductive health interventions" *Occasional Report No. 11*, Alan Guttmacher Institute, 2004.

³⁷ World Health Organization, *Unsafe abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2003* (Geneva, WHO, 2007).

with total fertility and most countries with increases in contraceptive prevalence have experienced fertility reductions.

Figure III

Total fertility versus contraceptive prevalence in developing regions, 1985-2005



Source: *World Contraceptive Use 2007* (United Nations publication, Sales No. E.08.XIII.6).

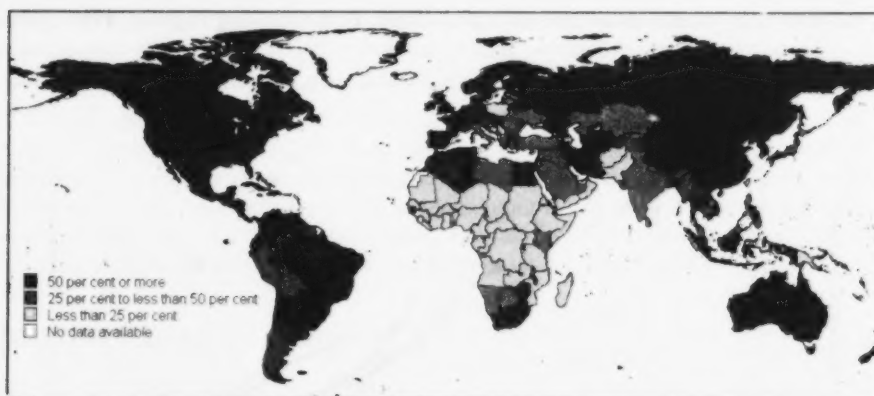
^a Eastern Africa, Middle Africa and Western Africa, only.

45. Globally, modern contraceptive methods³⁸ account for most contraceptive use. In 2003, 56 per cent of women aged 15-49 who were married or in union relied on modern contraceptive methods, up from 50 per cent in 1993. Use of modern methods surpassed 50 per cent in most countries in the Americas, Asia and Europe (see figure IV), but it was a low 15 per cent in sub-Saharan Africa and 21 per cent in the developing regions of Oceania. The use of traditional methods of contraception,³⁹ which are generally less effective in preventing pregnancy, is relatively high in Eastern Europe, Middle Africa and Western Africa. To the extent that the high prevalence of traditional methods is the result of constraints in accessing modern methods, it indicates that efforts to improve the accessibility and affordability of modern methods are still necessary to ensure universal reproductive health.

³⁸ Modern contraceptive methods include sterilization (female or male); hormonal pills, injectables and implants; intra-uterine devices (IUDs); condoms; and vaginal barrier methods.

³⁹ Traditional methods include rhythm, withdrawal, breastfeeding, douching and various folk methods.

Figure IV
Percentage of women aged 15-49, married or in union, using a modern contraceptive method, 2005



Source: *World Contraceptive Use 2007* (United Nations publication, Sales No. E.08.XIII.6).

46. Despite the high contraceptive prevalence achieved so far, there are still an estimated 106 million married women in developing countries with an unmet need for family planning,⁴⁰ including 66 million in Asia, 30 million in Africa, and 10 million in Latin America and the Caribbean. In India alone, 27 million married women have an unmet need for contraception. Other countries with high numbers of married women with unmet need include Pakistan, with more than 8 million, and Bangladesh, Ethiopia, Indonesia and Nigeria, each with over 3 million. In relative terms, unmet need is highest in most of sub-Saharan Africa (table 7) and in the least developed countries. Nearly a quarter of the countries in Africa with data available have unmet need levels surpassing 30 per cent, and about half have levels ranging from 20 to 30 per cent. In contrast, in Asia, Europe and Latin America and the Caribbean, the majority of countries with the required data display levels of unmet need below 20 per cent. The exceptions are mainly the least developed countries in those major areas, including Cambodia, Haiti, the Lao People's Democratic Republic, Nepal and Yemen, all of which had unmet need levels above 25 per cent, and Azerbaijan, Belize, Bolivia, Bulgaria, Guatemala and Pakistan, with unmet need levels ranging from 20 to 30 per cent.

⁴⁰ Women with unmet need are those who are fecund and sexually active but are not using any method of contraception and report *not wanting* any more children or wanting to delay the next pregnancy. This measure of unmet need is a robust indicator of additional demand for contraception because it reflects the disjuncture between reproductive intentions and contraceptive behaviour.

Table 7
Trends in unmet need for family planning, developing regions, 1995 and 2005

	Unmet need (percentage)		Annual decline (percentage points)
	1995	2005	
Northern Africa	16.3	10.4	0.59
Sub-Saharan Africa	25.7	24.1	0.16
South-Eastern Asia	12.8	11.1	0.17
Southern Asia	19.1	14.8	0.43
Western Asia	16.4	12.2	0.42
Latin America and the Caribbean	12.4	10.5	0.19

Source: The Millennium Development Goals Report 2008 (New York, United Nations, 2008).

Note: These regions are consistent with those used to report on Millennium Development Goals targets.

47. Since the 1990s, unmet need for family planning has generally declined, partly because of concerted efforts by Governments and the international community to make modern contraceptive methods more widely available. Substantial declines were achieved by Northern Africa, Southern Asia and Western Asia (see table 7). Average annual declines were slower in South-Eastern Asia and Latin America and the Caribbean, partly because both regions had already reached moderate levels of unmet need by 1995. The slowest decline was experienced by sub-Saharan Africa, where unmet need remains high. Furthermore, in four countries of sub-Saharan Africa — Benin, Chad, Mali and Uganda — unmet need increased.

48. While unmet need has generally been declining, total demand for family planning, defined as the sum of unmet need plus current contraceptive use, has been increasing in most countries. The pace of increase has been particularly rapid in Eastern Asia and South-Central Asia, averaging 1 percentage point per year. In comparison, the increase in sub-Saharan Africa has been moderate, at 0.6 percentage points per year, although rapid increases in demand have been recorded in selected countries in the region. Thus, Mozambique, Namibia, Uganda and Zambia have seen demand rise by more than 1.5 percentage points per year. Nevertheless, total demand for family planning remains low in sub-Saharan Africa, at less than 50 per cent, especially in comparison to that in Northern Africa (65 per cent), Asia (75 per cent), and in Latin America and the Caribbean (80 per cent). In addition, in 79 per cent of the 36 countries in sub-Saharan Africa having the required data, 59 per cent or more of the unmet need for family planning stemmed from the desire of women to delay their next pregnancy rather than from their wish to stop childbearing altogether. In contrast, the majority of unmet need in the additional 44 developing countries was associated with the desire of women to stop childbearing. Only in four countries outside sub-Saharan Africa — Albania, the Dominican Republic, Guatemala and Timor-Leste — did 55 per cent or more of unmet need stem from the desire of women to delay a future pregnancy.

49. During the transition from high to low fertility, unmet need for family planning is low at first, when large families are the norm, increases as fertility starts declining and drops when low fertility is achieved. Because fertility has started to decline in most of the countries lagging behind in the transition, countries with high

fertility are likely to have high levels of unmet need. The data available corroborate this expectation: among the 28 countries with data on unmet need referring to 2000 or later and a total fertility of at least 4.0 children per woman, 82 per cent had levels of unmet need surpassing 20 per cent. Satisfying the need for family planning will speed the transition to lower fertility in such countries.

50. Women face several barriers in satisfying their unmet need for family planning. In Benin, Burkina Faso, Ethiopia, Mali, Mozambique, Nepal, Peru and Uganda, for instance, between 10 per cent and 19 per cent of women with unmet need cited lack of services or difficulties accessing them as the main reason for not using contraception. Lack of awareness and information about family planning methods was another common cause of non-use, as reported by between 10 per cent and 15 per cent of women with unmet need in seven African countries and in Bolivia. The high cost of contraceptives was also mentioned but by lower proportions of women (12 per cent in Burkina Faso was the maximum).

51. Government efforts to provide access to family planning and modern contraceptive methods have been an important determinant of reproductive behaviour. Among developing countries, such support has risen steadily. In 2007, 86 per cent of developing countries provided direct support for family planning, up from 82 per cent in 1996.¹³ Direct support entails the provision of services through government-run facilities, including hospitals, clinics, health centres, or through government fieldworkers. Among developed countries, where concern about low fertility is common, direct support to facilitate access to modern contraceptive methods has been declining. In 2007, 39 per cent of Governments of developed countries provided such support, down from 58 per cent in 1996.

Figure V

Percentage of women aged 15-49 who are married or in union and who have unmet need for family planning



Source: *World Contraceptive Use 2007* (United Nations publication, Sales No. E.08.XIII.6).

V. Promoting gender equality and empowering women

52. Both the Programme of Action and the Millennium Declaration call for the achievement of gender equality and the empowerment of women, recognizing that both are key to combating poverty, hunger and disease and in achieving sustainable development. The Programme of Action sets a broad agenda for the improvement of the status of women, stressing the importance of increasing their equal participation and equitable representation at all levels of the political process; improving women's ability to earn an income in varied occupations so that they can become economically self-reliant, ensuring their equal access to the labour market and social security, and ensuring their equal rights to buy, hold and sell property and land, to obtain credit and negotiate contracts in their own name, and to exercise their right to inheritance (paras. 4.4 and 4.6).

53. The Programme of Action also stresses that education is a crucial means of empowering women with the knowledge and skills necessary to participate fully in the development process (para. 4.2) and urges Governments to ensure the widest and earliest possible access of girls and young women to secondary and higher levels of education, and to vocational education and technical training so as to close the gender gap in primary and secondary education by 2005 (para. 11.8), objectives consistent with the target of eliminating gender disparity in primary and secondary education by 2015 under Millennium Development Goal 3. Important progress has been made in closing those gaps. Between 2000 and 2006, the primary school enrolment of girls increased more than that of boys in all developing regions and two thirds of developing countries have achieved gender parity in primary education. However, girls still account for 55 per cent of the children who are out of school in developing countries and in Northern Africa, sub-Saharan Africa, Oceania and Western Asia the enrolment of girls in primary school still falls below that of boys.⁴¹ Those disparities widen with respect to secondary school enrolment: in those four regions, the ratio of girls' secondary school enrolment to that of boys varies from 80 to 88, still far below the target of 100.

54. Delaying marriage and the onset of childbearing is important to ensure that girls and young women remain in school as long as possible and gain the skills necessary to improve their labour market prospects. Thus, a study in Latin America and the Caribbean showed that there would be significant increases in the secondary school enrolment of female adolescents if dropping out of school because of pregnancy could be avoided.⁴² Reducing adolescent fertility is a major objective of Governments: among the 185 expressing a view on the issue, 91 per cent were concerned about their level of adolescent fertility, including virtually all the Governments of countries in Latin America and the Caribbean and most in Africa. In addition, 80 per cent had policies or programmes to address adolescent fertility. Despite such commitment, the reductions of adolescent fertility achieved in developing countries between 1990 and 2000 have not been replicated after 2000 and adolescent fertility remains high in many developing regions, especially in sub-Saharan Africa (119 births per 1,000 women aged 15-19), Latin America and the Caribbean (73), Oceania (63), South Asia (54) and Western Asia (50). Thus, even in regions where overall fertility is low, adolescent fertility has failed to decline

⁴¹ *The Millennium Development Goals Report 2008* (New York, United Nations, 2008).

⁴² Parfait Eloundou-Enyegue and C. Shannon Stokes, "Teen pregnancy and gender inequality in education: A contextual hypothesis", *Demographic Research*, vol. 11, 2004.

commensurately, partly because of early marriage and the barriers faced by young women to access family planning.

55. The Programme of Action recognizes that it is essential for all women to have access to affordable, acceptable and convenient reproductive health care in order to achieve control over their reproductive lives and the timing of their pregnancies to fit their family, education and work plans. Realizing the reproductive rights of women is therefore essential for their empowerment. Thus, the Programme of Action stresses that both women and men should "have access to the information, education and services needed to achieve good sexual health and exercise their reproductive rights and responsibilities" (para. 7.36 (b)). It further emphasizes men's shared responsibility and promotes their active involvement in responsible parenthood; sexual and reproductive behaviour; prenatal, maternal and child health; prevention of unwanted and high-risk pregnancies; prevention of sexually transmitted diseases, including HIV; shared control and contribution to family income, children's education, health and nutrition; and recognition and promotion of the equal value of children of both sexes (para. 4.27). Full implementation of the Programme of Action entails, therefore, both the empowerment of women in all spheres of life and a greater involvement of men in the exercise of reproductive rights and responsibilities.

56. A correlate of these objectives is that there should be zero tolerance for gender-based violence that puts the health and lives of women at risk. The social and economic costs of violence against women are enormous. Gender-based violence is more common in societies with gender norms that restrict women's autonomy and where women are subject to restrictive laws on divorce and on ownership and inheritance of property. Violence against women is associated with higher probabilities of contracting sexually transmitted diseases, including HIV, and of having unintended pregnancies and adverse pregnancy outcomes, including miscarriage, stillbirths and low birth weight. Abused women lose their self-confidence and see their education and employment opportunities curtailed. Eliminating gender-based violence would therefore not only eliminate its adverse effects on the health of women and children but also enhance their education and labour force participation.

VI. Ensuring environmental sustainability

57. During the twentieth century, the world population quadrupled and the urban population increased thirteenfold. This rapid growth and redistribution of the population occurred concomitantly with a fourteenfold increase in total production, a doubling of land under cultivation, a fivefold increase in irrigated area, a ninefold increase in water use and a thirteenfold increase in energy consumption,⁴³ which, together, are having unprecedented impacts on the environment, causing climate change, land degradation and loss of biodiversity.⁴⁴ Although population growth is

⁴³ Peter Marcotullio, "Socio-ecological systems and urban environmental transitions in the Asia-Pacific region", paper presented at the United Nations Expert Group Meeting on Population Distribution, Urbanization, Internal Migration and Development, New York, 21-23 January 2008.

⁴⁴ United Nations Environment Programme, *Global Environment Outlook: Environment for Development 4* (GEO-4), 2007.

but one of the factors leading to the changes under way, slowing population growth can buy time to adapt to those changes and, particularly in low-income countries, reduce the efforts needed to mitigate their negative effects. Reducing population growth is also a means of ensuring that, as the Programme of Action calls for, the needs of present generations are met without compromising the ability of future generations to meet their own needs (paras. 3.3 and 3.4 (a)).

58. The use of natural resources and access to energy are essential for development, but their by-products have proven to be detrimental to the environment. The Intergovernmental Panel on Climate Change has concluded that increases in emissions of greenhouse gases and especially of carbon dioxide (CO₂) are responsible for climate change. Until recently, countries of the Organization for Economic Cooperation and Development (OECD) generated the majority of CO₂ emissions but around 2005, CO₂ emissions from non-OECD countries surpassed those from OECD countries and are expected to continue outstripping the former because of both the rapid economic growth of emerging economies and higher population growth in non-OECD countries.⁴⁵ However, the relation between population growth and increasing greenhouse gas emissions is not straightforward and the scenarios of future emission trends do not permit assessing the effects of population dynamics net of economic and technological changes. Furthermore, changing population age structures, increasing urbanization and changes in household size interact in affecting emissions.⁴⁶

59. Maintaining adequate access to water for growing populations is a major concern. Today, 2.8 billion people live in river basins with some form of water scarcity⁴¹ and water-stressed regions exist in every continent. In addition, 1.6 billion people live in areas where lack of human, institutional or financial capital limit access to water, particularly in much of Southern Asia and sub-Saharan Africa. Although 1.6 billion people have gained access to safe drinking water since 1990, in sub-Saharan Africa just 58 per cent of the population has such access and the slow progress made so far suggests that the region will not reach the target of halving by 2015 the proportion of people without access to safe drinking water (Millennium Development Goal 7). Eastern Asia has extended the provision of improved drinking water to 400 million additional persons since 1990 and all regions in Asia are on schedule to meet the Goal 7 target. Nevertheless, per-capita availability of fresh water in Asia declined by 40 to 60 per cent during 1955-1990 and most Asian countries are likely to face severe water shortages by 2025.⁴⁷ Because population growth increases demand for water in all sectors of the economy, including agriculture, moderating that growth will make it easier to conserve water, make the investments necessary to make water accessible and increase the time available for adaptation to future conditions.

60. In 2008, the number of urban dwellers surpassed the number of rural inhabitants and, in future, population growth will be concentrated mainly in the urban areas of developing countries. Because in most developing countries urban

⁴⁵ World Bank, "Development and Climate Change: A Strategic Framework for the World Bank Group", consultation draft, 2008.

⁴⁶ Brian C. O'Neill, "The role of demographics in emissions scenarios", report of the Intergovernmental Panel on Climate Change Expert Meeting on Emission Scenarios, 12-14 January 2005, Washington, D.C.

⁴⁷ Intergovernmental Panel on Climate Change, "Technical Working Paper VI", 2008.

dweller have better access to services than rural inhabitants, rural-urban migration is a means of gaining access to those services. However, the rapid growth of urban settlements in some countries has strained the capacity of their Governments to provide adequate services to all urban dwellers and the number of slum-dwellers remains high, at 840 million persons or 37 per cent of the urban population of developing countries.⁴⁸ Nine out of 10 slum-dwellers lack adequate sanitation or live in crowded conditions. Improving access to sanitation is a low-cost intervention that can improve the lives and health of millions. Since 1990, an additional 1.1 billion people have gained access to improved sanitation facilities in developing countries but coverage still needs to be extended to 1.6 billion by 2015 to achieve the target of halving the proportion of people without access to sanitation (Millennium Development Goal 7).⁴¹ In urban areas, improvements in sanitation have failed to keep pace with urban population growth, particularly in sub-Saharan Africa. Yet globally, 70 per cent of those without improved sanitation live in rural areas. Consequently, as the Programme of Action recommends, "while vast improvements in the urban infrastructure and environmental strategies are essential in many developing countries to provide a healthy environment for urban residents, similar activities should also be pursued in rural areas" (para. 9.4).

VII. Global partnership for development

61. The Programme of Action foresaw the need to mobilize additional financial resources from both domestic sources and donors in order to implement population-related programmes that would respond to its core recommendations. In particular, funding would be needed for four components of population programmes focusing on: (a) family planning services; (b) basic reproductive health-care services to improve maternal health; (c) prevention of sexually transmitted diseases, including HIV/AIDS, and (d) basic research and data on population and development, including capacity-building (para. 13.14). Estimates were provided for the cost of implementing these four components in developing countries and countries with economies in transition (para. 13.15) and it was expected that two thirds of the costs would be borne domestically and one third from external sources.

62. Recently, domestic expenditures for population activities have been increasing in all regions, having reached \$23 billion in 2006. About 30 per cent of all domestic expenditures are devoted to the prevention and treatment of STDs and HIV/AIDS⁴⁹ but, in sub-Saharan Africa, 88 per cent of domestic spending goes to HIV/AIDS programmes. Donor assistance for population activities increased markedly after 2001, following a period of no growth that started in 1995. However, rising donor funding results mostly from increasing allocations to AIDS treatment, whereas donor support for family planning has declined. Between 1996 and 2005, per capita donor assistance devoted to family planning dropped by 80 per cent in sub-Saharan Africa, 70 per cent in Latin America and the Caribbean, nearly 65 per cent in Northern Africa and Western Asia, and 47 per cent in Asia and the Pacific (see figure VI).

63. Investment in family planning that allows women to have the number and spacing of children they want is likely to reduce fertility and be cost-effective. Thus,

⁴⁸ See E/CN.9/2008/3, para. 54.

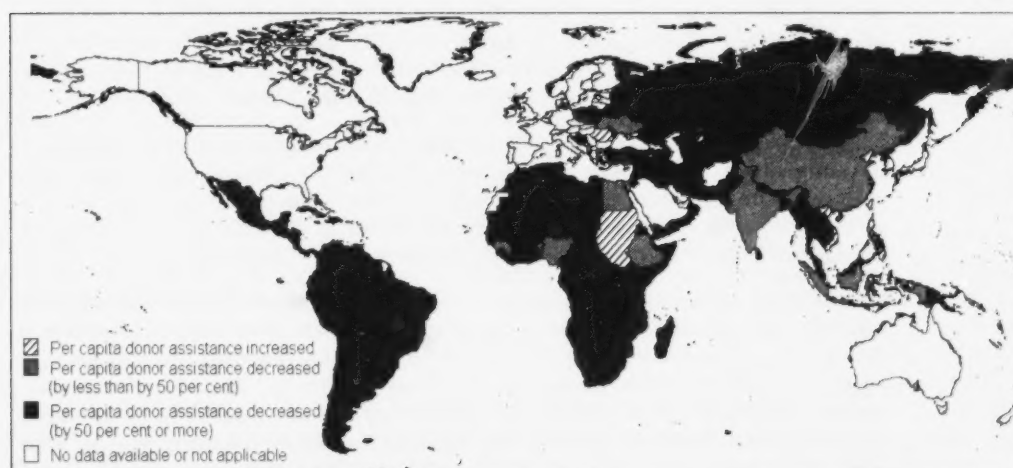
⁴⁹ See E/CN.9/2008/5, para. 22.

provision of a very basic package of health services costs \$45 annually per person, well above current health spending in most low-income countries.⁵⁰ If fertility were reduced by 2015 to the levels envisioned in the low variant of the United Nations projections, the population of the least developed countries would be 21 million lower in 2015 than in the medium variant,⁵¹ implying an annual savings approaching \$1 billion by 2015.

64. Although new pledges to fund family planning have been made recently, funding is not keeping pace with rising demand, especially in the low-income countries, putting in jeopardy not only the attainment of universal reproductive health but also of all the other goals on health, gender and education that are dependent on achieving that target.

Figure VI

Percentage change in donor assistance for family planning programmes per woman aged 15-49, 1996 to 2006



VIII. Conclusions and recommendations

65. The full implementation of the Programme of Action of the International Conference on Population and Development can make a significant contribution to the achievement of the internationally agreed development goals. Fifteen years after its adoption, gaps in implementation are particularly common in the least developed countries and most of those in sub-Saharan Africa and they have hindered progress in the achievement of crucial development goals, including the Millennium Development Goals. Since the 1970s, government policy buttressed by donor support has been successful in

⁵⁰ Countdown Working Group on Health Policy and Health Systems, "Assessment of the health system and policy environment as a critical complement to tracking intervention coverage for maternal, newborn, and child health", *The Lancet*, vol. 371, 2008.

⁵¹ The medium and low variants differ only in the projected fertility level. In 2015, projected fertility for the least developed countries is 3.69 in the low variant and 4.15 in the medium variant, a difference of 0.46 children per woman.

averting a global "population explosion" but population growth remains high in many low-income countries. High population growth resulting from sustained high fertility imposes increasing demands on existing resources and reduces the capacity of Governments to respond to new challenges.

66. Fertility decline reduces the proportion of dependants in a population, leading to a period where demographic change can boost economic growth if supported by measures to build human capital, generate jobs, increase savings and improve income distribution. Fertility decline can also contribute to reduce poverty and hunger, at both the national and household levels. Families with fewer children can invest more on the health, nutrition and education of each child. Intergenerational transfer accounts indicate that countries with lower fertility spend substantially more in the health and education of children than countries with higher fertility. Slower growth in the number of children makes it easier to achieve universal primary education.

67. High fertility is associated with the persistence of poverty within countries because low-income groups generally have higher natural increase than high-income groups. Consequently, reducing fertility among poor households can contribute to reduce poverty, both directly and indirectly. High fertility among the poor can contribute to the intergenerational reproduction of poverty.

68. Policies to address the effects of food price shocks should give priority to the immediate protection of the most vulnerable, including women and children. Longer-term responses should incorporate population policy as part of a coordinated response to promote sustainable livelihoods for all by helping households avoid the intergenerational reproduction of poverty.

69. Despite progress made in providing access to modern contraceptive methods to those who need them, an estimated 106 million married women in developing countries have an unmet need for family planning. Satisfying that need can contribute to reducing maternal mortality, improving maternal health, reducing child mortality, promoting gender equality, combating HIV/AIDS and reducing poverty. Yet, funding for family planning has not kept pace with increasing demand. Between 1996 and 2005, per capita donor assistance devoted to family planning dropped in most regions. In sub-Saharan Africa, the high prevalence of HIV/AIDS has meant that most domestic spending on reproductive health is devoted to AIDS treatment. Substantial increases in both domestic and external funding for family planning are necessary if reproductive health for all is to be assured by 2015.

70. Closely spaced births and pregnancies in adolescent and older women put children at increased risk of death. In order to accelerate the reduction of child mortality, particularly in low-income countries with high fertility, expanded access to family planning combined with reinvigorated efforts to expand interventions to improve child health is crucial to ensure the achievement of Millennium Development Goal 4.

71. The reduction of maternal mortality depends on ensuring that women have access to antenatal care during pregnancy, to trained health attendants during delivery and to emergency obstetric care if complications arise. Access to family planning, by allowing women to avoid mistimed and unwanted pregnancies, reduces their lifetime risk of maternal mortality. Moreover, fewer

pregnancies lower the overall cost of providing safe motherhood services to women giving birth.

72. Antenatal care and family planning services should include the provision of information and counselling on HIV/AIDS as well as voluntary testing to identify women in need of treatment and to prevent mother-to-child transmission of HIV. Family planning can enable HIV-positive women to avoid unwanted pregnancies and thus reduce the prevalence of HIV among children.

73. In countries where malaria is endemic, antenatal care should include the provision of intermittent anti-malarial treatment for pregnant women and the distribution of insecticide-treated bed-nets. In the medium term, improved access to family planning can reduce the cost of malaria control by reducing the population at risk.

74. Achieving gender equality, equity and the empowerment of women is important in combating poverty, hunger and disease and in achieving sustainable development. Education is a crucial means of empowering women with the knowledge, skills and self-confidence necessary to participate fully in the development process. Delaying marriage and the onset of childbearing helps to ensure that girls and young women remain in school and gain the skills necessary to improve their labour market prospects. Secondary school enrolment of female adolescents would increase further if dropping out of school because of pregnancy could be avoided.

75. Although the relation between population growth and increasing greenhouse gas emissions is not straightforward and it is not yet possible to assess the effects of population dynamics net of other economic and technological changes, reducing population growth can buy time to adapt to those changes and, particularly in low-income countries, reduce the efforts needed to mitigate their negative effects.

76. Maintaining adequate access to water for a growing world population is a challenge. Because population growth increases the demand for water in all sectors of the economy, including agriculture, moderating that growth will make it easier to conserve water, make the investments necessary to make water accessible to more people and expand the coverage of sanitation to meet the targets set under Millennium Development Goal 7.

77. Asia's population is today just over 4 billion instead of surpassing the 6 billion mark, as it would have done had its fertility remained constant at 1970 levels, because 68 per cent of Asian women aged 15-49 who are married or in union use some method of contraception. In sharp contrast, contraceptive prevalence in sub-Saharan Africa is a low 22 per cent, having failed to reach the modest level of 31 per cent that was forecast in 1994 and served as basis for estimating the level of funding that would have been required to reach the goals and objectives set out by the Programme of Action. Such disparities in implementation hinder the achievement of the Millennium Development Goals. With scarcely six years to go to reach them, priority should be given to the reduction of those implementation gaps.



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**Follow-up actions to the recommendations of the
International Conference on Population and Development**

Monitoring of population programmes, focusing on the contribution of the Programme of Action of the International Conference on Population and Development to the internationally agreed development goals, including the Millennium Development Goals

Report of the Secretary-General

Summary

The present report on the contribution of the Programme of Action of the International Conference on Population and Development to the internationally agreed development goals, including the Millennium Development Goals, has been prepared in response to the topic-oriented and prioritized multi-year work programme of the Commission on Population and Development, as stipulated in resolution 2006/1 of the Commission. In its decision 2007/1, the Commission decided that the contribution of the Programme of Action of the Conference to the internationally agreed development goals, including the Millennium Development Goals, should be the special theme for the forty-second session of the Commission, on the occasion of the fifteenth anniversary of the holding of the Conference.

* E/CN.9/2009/1.



The report reaffirms that population, reproductive health and gender issues are central to development and to the achievement of the Millennium Development Goals. Without a firm commitment to those issues, both through the achievement of their particular programmatic goals and by accounting for the impact of wider population trends on the achievement of goals in other areas, it will not be possible to meet the goals of the International Conference on Population and Development or of the Millennium Summit. The fifteenth anniversary of the Conference provides an excellent opportunity for the international community to assess the progress made in the implementation of the goals set at the Conference and to redouble efforts to meet the aims and objectives agreed to in Cairo in order to facilitate the achievement of the Millennium Development Goals.

The report describes the programmatic work of the United Nations Population Fund (UNFPA) to assist countries throughout the world in responding to the challenges of implementing the Programme of Action of the International Conference on Population and Development, especially as it contributes to the achievement of the Millennium Development Goals. The report sets out the strategic orientation of UNFPA and provides examples of its activities at the global, regional and country levels aimed at achieving the Millennium Development Goals relating to poverty reduction; gender equality and the empowerment of women; improving maternal and reproductive health; combating HIV/AIDS; and ensuring environmental sustainability.

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I. Introduction

1. The present report on the contribution of the Programme of Action of the International Conference on Population and Development¹ to the internationally agreed development goals, including the Millennium Development Goals, has been prepared by the United Nations Population Fund (UNFPA) in response to the topic-oriented and prioritized multi-year work programme of the Commission on Population and Development, as stipulated in resolution 2006/1 of the Commission. The special theme for the forty-second session of the Commission was adopted by the Commission on Population and Development in its decision 2007/1.

2. The report points out that population, reproductive health and gender issues are central to development and to the achievement of the Millennium Development Goals. At the major United Nations conferences of the 1990s, Governments and civil society gathered to address the global developmental, economic, environmental and social concerns facing humanity. The agreements reached at those conferences set out blueprints for concrete action to improve the situation of women, men and children everywhere by broadening their opportunities and by expanding their access to quality social services. The conferences also addressed such issues as the monitoring of the implementation of the goals and objectives of the programmes of action, international cooperation, the role of the United Nations, resource mobilization and follow-up activities at the national, regional and international levels. Their impacts were cumulative, and they each built on the principles and recommendations of their predecessors and pointed the way to the future.

3. Recognizing the need to re-energize and focus the United Nations development agenda, the Secretary-General convened the Millennium Summit in 2000. The outcome document, the Millennium Declaration,² provided guidance for a vision of sustainable development. In 2005, at the World Summit, world leaders gathered to assess the progress made since the Millennium Declaration and identify needs with regard to accelerated development in a changing environment. As a result of those deliberations, modifications were made to the original road map framework, adding targets and indicators relating to the Millennium Development Goals. Four new targets relating to universal access to HIV/AIDS treatment, universal access to reproductive health, the promotion of environmental sustainability and the recognition of the centrality of employment (particularly for women and young people) to poverty reduction were included in the revised monitoring framework for the Millennium Development Goals, after consideration by the General Assembly. As a result of that development, the convergence of the quantitative goals of the International Conference on Population and Development and the monitoring framework for the Millennium Development Goals was completed. As the international community commemorates the fifteenth anniversary of the Conference, the goals and objectives set in Cairo remain as relevant as ever if the Goals are to be achieved.

4. The present report focuses on key programmatic initiatives undertaken by UNFPA and its partners at the national, regional and global levels to implement the objectives of the Programme of Action of the International Conference on

¹ *Report of the International Conference on Population and Development, Cairo, 5-13 September 1994* (United Nations publication, Sales No. E.95.XIII.18), chap. 1, resolution 1, annex.

² Resolution 55/2.

Population and Development and to achieve the Millennium Development Goals. UNFPA work in this area shows that the implementation of the Programme of Action is essential to the achievement of the Goals, especially those related to eradicating poverty, promoting gender equality, improving maternal health, combating HIV/AIDS and ensuring environmental sustainability.

5. These key programmatic initiatives are guided by the UNFPA strategic plan, 2008-2011, which represents the conceptual and operational basis for the UNFPA contribution to the achievement of the goals of the Conference and the Millennium Development Goals over a four-year period. It guides the Fund's strategic approach in maximizing the role of the United Nations in supporting policy development, coordination and capacity development so as to ensure the implementation of international commitments on aid effectiveness and the achievement of the internationally agreed development goals.

6. The UNFPA strategic plan and programmes are based on the principles that drive United Nations reform, most importantly the recommendations of the 2007 triennial comprehensive policy review, as well as the new aid environment envisaged in the 2005 Paris Declaration on Aid Effectiveness. The shift in the role of UNFPA from the provision of project-related technical assistance to policy support, institution-building and the brokering of expertise reflects its recognition of the growing importance of capacity development and sustainability, which characterize the new aid environment and contribute more effectively to the scaling up of successful country-led initiatives to meet the Conference targets and Millennium Development Goals. The new approach taken by UNFPA to technical assistance also places greater emphasis on inter-agency cooperation and partnership-building. UNFPA programming focuses on harmonization and alignment, placing one national development plan at the centre of country development efforts; strong national ownership through coordinated national-capacity development; the use of national systems; greater predictability of aid flows; a results-oriented process; increasingly programme-based approaches; and mutual accountability, all of which are basic requirements for change in the new aid environment.

7. UNFPA recognizes that a new approach to technical support is essential for scaling up in order to accelerate progress towards the Millennium Development Goals. UNFPA will build on national and regional capacities; technical leadership, including research on and the development of new products; and the successful scaling-up experiences of certain large economies of the South, including those of Brazil, China, India, Mexico, South Africa and Thailand. A number of those countries have already started to provide technical support within their respective regions and subregions, building regional capacity for the implementation of the Conference targets and the Millennium Development Goals. New modalities for South-South cooperation through civil society organizations, universities, the private sector, networks and Governments offer unique opportunities for accelerating progress towards the Goals in developing countries.

8. UNFPA programmes provide support for the collection, analysis and dissemination of age- and sex-disaggregated data, which are essential for the effective planning, implementation and monitoring of progress in terms of both Conference targets and the Millennium Development Goals. UNFPA helps countries track and analyse changes in population size, structure, distribution and dynamics. The Fund works with global partners to raise awareness of the importance of data

collection, especially with respect to population censuses, vital statistics and household surveys. As the leader in the field of demographic data, UNFPA has lent its full support to preparatory activities for the 2010 World Population and Housing Census round, including in the preparation of resource mobilization and advocacy documents. UNFPA also provides support for other household and thematic surveys such as the demographic and health surveys, as well as for the development of databases and monitoring systems to facilitate the implementation of the Conference targets and the Millennium Development Goals.

II. Millennium Development Goal 1: Eradicate extreme poverty and hunger

9. At the International Conference on Population and Development, held in Cairo, countries agreed that investing in people, and empowering individual women and men through education, equal opportunities and the means to determine the number and spacing of their children were critical to breaking the cycle of poverty that traps millions of individuals and families and blocks the progress of human development. A central plank of the 1994 Cairo consensus was that the size, growth, age structure and rural-urban distribution of a country's population have a critical impact on its development prospects and on the living standards of the poor. As a result, the Conference, in paragraph 3.4 of the Programme of Action, called on countries to fully integrate population concerns into development strategies, planning, decision-making and resource allocation at all levels.

10. The world's poorest countries generally tend to have the highest fertility and population growth rates. Poverty in those countries also perpetuates poor health, gender inequalities and, consequently, fast population growth. These issues are connected by many pathways encompassing both the macro and the micro levels. At the macro level, recent evidence concerning the relationship between age structures, economic growth and poverty levels suggests that some countries have had considerable success in using declining fertility trends to their advantage. At the micro level, there is evidence that enabling people to have fewer children through investments in health, including reproductive health, HIV/AIDS prevention, family planning, education, women's empowerment and gender equality contributes to poverty reduction. Access to reproductive health care enables women and girls to enjoy equal opportunities with men in labour markets, balance their productive and reproductive roles and achieve their educational, professional and family goals. Thus, for instance, fewer, spaced pregnancies lead to lower economic dependency ratios within families, more income-generating opportunities for women and better education for children, which, in turn, can lead to higher family income and consequently less poverty in present and future generations. They also lead to lower maternal and child mortality and morbidity levels, which may further contribute to poverty reduction.

11. Educating girls and women places them in a more favourable position to obtain better-remunerated employment. Women who are educated tend to have children later and to have fewer of them, and they are more likely to invest their income in the health and education of their children, both of which are powerful ways to break the intergenerational transmission of poverty.

12. Most developing countries have large adolescent and youth populations. Reproductive health programmes that address the vulnerability of adolescents to unprotected sex, sexual coercion, HIV and other sexually transmitted infections, unintended early pregnancies and unsafe abortions, and enable young women to delay pregnancy and marriage can also help break the intergenerational cycle of dependence and poverty.

13. Finally, several of the current demographic trends in many parts of the world, such as population ageing, increasing urbanization and the social, economic and financial implications of international migration, modify the policy environment in which Governments plan for the achievement of the Millennium Development Goals. Such factors are often insufficiently reflected in current planning instruments and need to be dealt with more explicitly.

14. During the past several years, UNFPA has assisted many countries in their efforts to reduce poverty by improving access to reproductive health care, HIV prevention and family planning, which helped to contribute towards smaller families and more healthy populations. It has also assisted countries in the area of education, the fight against gender-based violence and the empowerment of women and girls, which contribute to poverty reduction. The long-standing assistance of UNFPA in the consideration of demographic factors in social and economic policies, including the collection and analysis of age- and sex-disaggregated statistics, including for poverty mapping, has helped countries to increase their potential for strategic planning. Below are some examples of UNFPA interventions over the past few years that were aimed at contributing to poverty reduction.

15. In several countries, UNFPA has been actively engaged in policy dialogue aimed at influencing the formulation of pro-poor policies such as national development plans, including poverty-reduction strategies and health-sector plans. UNFPA, guided by the Programme of Action of the Conference, has endeavoured, through such policy dialogues, to raise awareness of the linkages between population dynamics and poverty, emphasizing in particular the situation of women and young people and the positive effects that reproductive health care and family planning can have on economic and social development and poverty reduction.

16. For example, in 2007, UNFPA, together with the United Nations Development Programme (UNDP) and the World Bank, supported the process of formulating national development plans and poverty reduction strategy papers as well as population-related indicators in countries including Afghanistan, Armenia, Colombia, Jamaica, Kyrgyzstan, Niger, Nigeria, the Republic of Moldova, Rwanda and Zambia. In those countries, the advocacy and technical support provided by UNFPA during various stages of the preparation of the strategies contributed to the integration of the dimension of population, reproductive health and gender in their plans of action. In Brazil, UNFPA collaboration with the Government resulted in specific, quantified references in the 2007 report on the Millennium Development Goals to the importance of population and reproductive health-care issues in the context of poverty reduction in recent years. In Jamaica, through involvement in the health and population task forces, UNFPA contributed to the inclusion of population issues, reproductive health and rights, and gender equality in the national development plan. UNFPA in Kyrgyzstan built partnerships with the national committee of parliamentarians on population and development and jointly carried out awareness-raising activities for local administrative bodies on the integration of

population issues in national and local development plans. Advocacy and technical expertise during the process of formulating the poverty reduction strategy in the Niger and Rwanda helped to integrate the demographic dimension and the links between reproductive health, gender and poverty reduction within the strategy document, under Government leadership. In the case of Nigeria, UNFPA mobilized young people and supported their participation in the development of the draft poverty reduction strategy paper, so that their issues could be addressed in the proposed documents and actions.

17. Through the participation of UNFPA in the United Nations Millennium Project and a regional project in Latin America and the Caribbean, several documents were produced that may assist Governments in the consideration of issues related to population, reproductive health and gender in the formulation of poverty-reduction policies. The latter project also invested in the development of modelling tools that facilitate the quantification of some of the links between population and reproductive health on the one hand and poverty levels on the other.

III. Millennium Development Goal 3: Promote gender equality and empower women

18. UNFPA has contributed to the achievement of Goal 3 by addressing critical issues that are central to gender equality, including women's right to health and the right to live free from violence. In so doing the Fund is working at the global level, including through collaboration with other United Nations agencies and the building of partnerships with Governments, civil society organizations (including indigenous people's groups and faith-based networks) to promote women's leadership and implement the Beijing Platform for Action and the Programme of Action of the International Conference on Population and Development.

19. As co-convener of the United Nations Inter-agency Network on Women and Gender Equality Task Force on Violence against Women, UNFPA is working with the Division for the Advancement of Women to support 10 United Nations country teams in their efforts to prevent and respond to violence against women. In partnership with the Task Force, that exercise has begun in a number of pilot countries — Burkina Faso, Chile, Fiji, Jamaica, Jordan, Kyrgyzstan, Paraguay, the Philippines, Rwanda and Yemen — with baseline assessments and the development of joint multi-stakeholder proposals to address and eliminate violence against women through coordinated initiatives at the national level. UNFPA has also, in several countries, supported the work of the Special Rapporteur on violence against women, its causes and consequences.

20. UNFPA is one of the founding members of United Nations Action against Sexual Violence in Conflict — an inter-agency body comprising 12 United Nations agencies. UNFPA has contributed to many activities at the country level, including awareness-raising campaigns advocating the extension of Security Council resolution 1325 (2000) in Côte d'Ivoire. In Lebanon, UNFPA conducted sensitization sessions with local politicians and male peacekeepers to promote respect for women and girls of host communities. Together with other United Nations entities, UNFPA will provide ongoing support to the Secretary-General's multi-year campaign "Unite to End Violence against Women", which aims to increase public awareness, political will and resources for preventing and

responding to violence against women and girls. UNFPA provides services and reproductive health commodities to victims and survivors of gender-based violence in crisis and post-conflict settings and responds to the particular needs of women and girls affected by conflict, natural disasters and the impacts of climate change throughout the world. In 2007, for example, UNFPA responded to humanitarian crises in 54 countries.

21. The joint programming initiative by UNFPA and the United Nations Children's Fund (UNICEF) to accelerate abandonment of the practice of female genital mutilation/cutting and reduce prevalence rates by 40 per cent in 17 countries is well under way in 8 countries, namely, Djibouti, Egypt, Ethiopia, Guinea, Guinea-Bissau, Kenya, Senegal and the Sudan. Also in partnership with UNICEF, UNFPA is developing training and advocacy materials on linkages between the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination against Women, to improve programming within United Nations country teams so as to support the human rights of women and girls.

22. UNFPA, in collaboration with the United Nations Development Fund for Women, is promoting economic empowerment for women at the strategic planning level through gender-responsive budgeting. In recognizing the value of gender-responsive budgeting as a means to more equitable and responsive planning, both agencies have been undertaking capacity development for their staff in the area of gender-responsive budgeting through the development of knowledge products and training workshops at the global and regional levels.

23. Many UNFPA-supported projects emphasize the role of men in reproductive health, targeting different groups of men, from uniformed personnel to religious leaders. In that context, UNFPA partnered with the World Health Organization (WHO), civil society organizations and police and military bodies to develop capacity-building tools that assist staff and partners in the process of involving men and boys on issues of sexual and reproductive health, maternal and child health, fatherhood, HIV/AIDS and gender-based violence prevention.

IV. Millennium Development Goal 5: Improve maternal health

24. Since the adoption of the Goals in 2000, there has been a clear linkage between Goal 5 and the reproductive health goals of the International Conference on Population and Development, as improving maternal health is a major element of sexual and reproductive health. The overall vision of the Conference with respect to universal access to reproductive health care and its critical role in the achievement of the Millennium Development Goals was reaffirmed at the 2005 World Summit. In October 2007, the target of universal access to reproductive health care was added to Goal 5.

25. Following the International Conference on Population and Development, many countries enacted policies on sexual and reproductive health and began to implement programmes within the health system. According to a 2004 UNFPA survey, about 86 per cent of countries had adopted policy measures, laws or institutional changes at the national level to promote or enforce reproductive rights, and 54 per cent had formulated new policies. Where country policies, budgets and programmes have reflected the goals of the Conference, progress has been made. More women now have access to contraceptives. At least a dozen middle-income

countries, and even a few low-income ones, have reduced their maternal-mortality rates. The rate of new HIV infections has decreased for the first time in some countries of sub-Saharan Africa.

26. Despite the considerable progress made since the Conference, millions of people — mostly disadvantaged women and adolescents — still lack access to sexual and reproductive health information and services. In developing countries, about 201 million married women lack access to modern contraceptives. Each year, there are about 340 million new cases of sexually transmitted infections and 2.7 million new HIV infections. Millions of women and adolescent girls continue to die or become disabled during pregnancy and childbirth. It was estimated in 2005 that maternal mortality ratios had decreased globally by less than 1 per cent annually between 1990 and 2005, far short of the rate needed to achieve Goal 5.

27. UNFPA has supported the development and implementation of national strategies and programmes aimed at promoting reproductive health in countries around the world. UNFPA emphasizes the integration of a package of sexual and reproductive health services in the basic health services delivered at the district and local levels, in particular primary health care. The package should universally include family planning services; pregnancy-related services, including skilled attendance at delivery, emergency obstetric care and post-abortion care; sexually transmitted infection and HIV prevention and diagnosis and STI treatment; prevention and early diagnosis of breast and cervical cancers; prevention of gender-based violence and care of survivors; and essential commodities for each component. For example, in Kyrgyzstan, with a view to supporting the Government's focus on primary health care in its health reform, UNFPA introduced the WHO training package on integrated reproductive health services at the primary health-care level through a training of trainers for family doctors and nurses. The training package is expected to be integrated into the national medical training programme. In Kenya, UNFPA has worked with the Government to ensure that sexual and reproductive health and HIV/AIDS are one of the six pillars of the Kenya Essential Package for Health and to secure commitments for reproductive health commodities. In Latin America, several partners, including the Pan American Health Organization, the Swedish International Development Cooperation Agency and the Centre for Health Research of Nicaragua, have organized training courses for governmental and non-governmental organizations representatives of countries in the region on the strengthening of health systems, utilizing maternal health as a cross-cutting issue to analyse and propose innovative approaches to the various dimensions of the health-care system.

28. Recognizing the changing aid environment and addressing United Nations reforms in the framework of "One UN", UNFPA has been engaged in the implementation of new mechanisms for improved aid effectiveness in support of the achievement of Goal 5. UNFPA engagement in health-sector-wide approaches has reached 30 countries; in 12 of them, contributions to joint/pooled funding, are included. For example, UNFPA is engaged in mature sector-wide-approach processes in countries including Bangladesh, Ethiopia, Ghana, Malawi, Mali, Nicaragua, Uganda, the United Republic of Tanzania and Zambia, providing technical support to ensure that Goal 5 is fully integrated in national health plans and budgets. In Burundi, UNFPA has been actively engaged in the early stages of developing the sector-wide-approach which will utilize two indicators related to both the International Conference on Population and Development and Goal 5 —

the percentage of deliveries that take place in health facilities and the rate of modern contraceptive use — among the five chosen to monitor progress. In the United Republic of Tanzania, the contribution of UNFPA to the health-sector basket since 2004 has contributed to increased visibility and the leveraging of resources for priority reproductive health issues, including maternal and newborn health and reproductive health commodities.

29. UNFPA is active in the H8, an informal group of eight international agencies active in the area of health (WHO, UNICEF, the Joint United Nations Programme on HIV/AIDS (UNAIDS), the World Bank, the Bill and Melinda Gates Foundation, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the Global Alliance for Vaccines and Immunization), aimed at better coordination, particularly at the country level. The group recognizes the need to strengthen health-care systems and improve service delivery in support of national processes. UNFPA is also an active player in International Health Partnership Plus, an initiative comprising United Nations agencies, private foundations, Governments and donors, whose main objective is to support national efforts to scale up coverage towards achieving global health outcomes, particularly the health-related Millennium Development Goals. UNFPA has been engaged in all of the active countries³ to ensure that Goal 5 is included in national health strategies, plans, budgets and health information systems. UNFPA is also working with the Harmonization for Health in Africa initiative, with the goal of optimizing and harmonizing efforts across six key agencies (the African Development Bank, UNAIDS, UNFPA, UNICEF, the World Bank and WHO) in support of nationally led processes to advance progress towards the health-related Millennium Development Goals.

30. UNFPA is committed to ensuring access to sexual and reproductive health services and information for adolescents and young people as part of a broader package of social services. UNFPA, in partnership with the European Union, supported seven countries in the Asia region in improving the sexual and reproductive health status of young people, addressing policies, services and education. For example, the programme in Viet Nam demonstrated a sustainable model for providing youth-friendly services in rural communities through their integration in Government services. In Mozambique, Geração Biz, a UNFPA-supported project designed and developed by young people with technical assistance from Pathfinder International, reaches both in-school and out-of-school youth through a variety of activities, including sports, youth centres and school- and community-based interventions. UNFPA, in partnership with WHO, has also helped the Government of India vastly expand its services to young people by providing strategic, technical and operational guidance to the Ministry of Health and Family Welfare in the integration of adolescent-friendly service centres into the primary health-care infrastructure in 75 districts. The Fund continues to be involved in sexual and reproductive health education in most countries, with reviews showing notable benefits for young people. In Latin America, UNFPA established a strategic partnership with the Andean Regional Health Organization to implement a regional plan on adolescent pregnancy prevention, resulting in the adoption of a resolution by the network of Ministers for Health of the Andean region. Furthermore, the Ministers for Health and Education of Latin America and the Caribbean signed a

³ Africa: Benin, Burkina Faso, Burundi, Ethiopia, Ghana, Kenya, Madagascar, Mali, Mozambique, the Niger and Zambia; Asia: Cambodia and Nepal.

historic declaration pledging to provide comprehensive sex-education and sexual health promotion programmes, including on HIV prevention.

31. UNFPA has also promoted participation by young people in the process of advancing their reproductive health rights. The UNFPA Global Youth Advisory Panel, which is composed of young people from both developing and developed countries, provides advice on promoting the rights and needs of youth. UNFPA has also long supported youth networks in various regions. For instance, UNFPA has supported the Youth Peer Education Network (Y-PEER), a global network of young people working in the area of adolescent sexual and reproductive health in Central and Eastern Europe, Central Asia, the Middle East, and both North and East Africa. In Africa, the African Youth Alliance, a partnership of UNFPA and the non-governmental organizations PATH and Pathfinder International, promotes participation by young people in programme design and implementation, with a view to improving reproductive health and preventing HIV in four African countries (Botswana, Ghana, Uganda and the United Republic of Tanzania).

32. UNFPA has since its inception supported countries in their efforts to improve access to and utilization of family planning services. Through programmes in 140 countries, UNFPA works with Governments to ensure that family planning is an integral part of national health plans and budgets, and that information and a range of family-planning methods are offered in all health facilities and reach all communities. For example, UNFPA was one of the key partners engaged in increasing access to and the utilization of family planning services in Rwanda. UNFPA assisted in the training of district health providers, supporting a national campaign to promote family planning and framing family planning in national development plans and frameworks.

33. A major requirement for the provision of family planning services is regular and reliable systems that ensure the availability of the necessary contraceptives. Consequently, UNFPA has been active in the global Reproductive Health Supplies Coalition and launched a special global programme in 2005 to support countries' efforts in this area. As a result, many countries have developed national strategies on this issue, some 77 countries have a budget line for reproductive health commodities, and there has been a substantial reduction in "stock-outs" of contraceptives in the countries with the poorest reproductive health indicators. In the Pacific region, UNFPA has helped to establish a regional plan for ensuring reproductive-health-commodity security, including a regional warehouse for storing commodities. In Afghanistan, UNFPA helped the Government to conduct an assessment and establish a plan for commodity security and is now supporting the implementation of the plan. In Armenia, with support from UNFPA, it was agreed that the Government would participate in contraceptive procurement for the first time since independence. In Mozambique, UNFPA advocated the inclusion of the Reproductive Health Supplies Coalition in the health sector strategic plan, resulting in a Government budget allocation for reproductive health commodities for the first time in 2007.

34. To address gaps in maternal care, Governments, with support from UNFPA and other agencies, are implementing plans to ensure functioning health systems that provide a continuum of maternal health care within the broader spectrum of sexual and reproductive health. UNFPA has been working closely with UNICEF, WHO and the World Bank to improve coordination in that area. In addition, UNFPA launched

the Thematic Fund for Maternal Health in January 2008. The Fund seeks to mobilize \$500 million over four years to boost support to the 60 countries with the highest maternal mortality rate, and work has already begun in 11 countries.⁴

35. At the regional level, more than 40 countries in Africa have developed national road maps for reducing maternal and newborn mortality and morbidity, with joint support from UNFPA, UNICEF and WHO. Malawi, for instance, has finalized, costed and mobilized resources for its national road map and has begun implementation of the operational plan under the health sector-wide approach. Numerous other countries are now mobilizing resources and beginning the implementation of their road maps.

36. UNFPA assists countries in their efforts to increase access to vital maternal health services, in particular skilled delivery care and emergency obstetric care. UNFPA has been providing support to a number of countries so as to increase the number and enhance the competencies of skilled birth attendants, in particular midwives. In Cambodia, for instance, UNFPA actively supported a midwifery review for the midterm review of the health-sector plan and is supporting the subsequent follow-up actions of a high-level midwifery task force. In Haiti, UNFPA has been supporting the Ministry of Health and the National School of Nurse Midwives to develop a policy and plan aimed at ensuring that midwives who have recently graduated can benefit from internships in maternity hospitals. To further these and other efforts, UNFPA launched a programme jointly with the International Confederation of Midwives in 2008 to strengthen national capacity in low-resource countries so as to increase skilled attendance at all births by scaling up the capacity of midwives. The programme is currently active in 11 countries in Africa and Asia.

37. UNFPA was a key partner in early efforts to demonstrate the viability of improving availability of and access to emergency obstetric care. Furthermore, UNFPA has supported assessments on the availability and quality of emergency obstetric-care services in more than 20 countries worldwide. UNFPA has also worked with Governments to fill key gaps in service coverage and quality. For instance, in Côte d'Ivoire, more than 100 maternity and gynaecology operating theatres have been equipped or rehabilitated and health workers were trained in emergency obstetric care, with UNFPA support. In Nicaragua, UNFPA has emphasized an inter-agency approach to emergency obstetric care, and, as a result of advocacy efforts, 90 per cent of hospitals are now actively implementing national norms and guidelines relating to emergency obstetric care. Working with UNICEF, WHO and the Government of Bangladesh, UNFPA is leading an effort to accelerate progress towards a reduction in maternal and neonatal mortality and morbidity and is supporting some 60 district-level health facilities to provide 24-hour access to emergency obstetric care in addition to antenatal and post-natal care. UNFPA is actively supporting the Sudan in its efforts to improve the quality of emergency obstetric care by helping to enhance clinical protocols and training health providers, in particular midwives, in clinical skills.

38. UNFPA is also involved in addressing the health problems, both physical and mental, relating to pregnancy and childbirth, which cause undue suffering and diminish quality of life for women. In 2003, UNFPA and partners launched the

⁴ Benin, Burkina Faso, Burundi, Cambodia, Djibouti, Ethiopia, Guyana, Haiti, Madagascar, Malawi and the Sudan.

global Campaign to End Fistula, which is now active in more than 45 countries. In the Niger, a national network supported by UNFPA is actively coordinating the national action plan and providing innovative models for the reintegration of women living with fistula. In Pakistan, support from UNFPA has helped to increase coverage of fistula-treatment services to seven centres nationwide. Other morbidities are now also gaining attention. In Nepal, for instance, UNFPA, the Government and non-governmental organizations have launched a national strategy and campaign against uterine prolapse. Recognizing the high prevalence of perinatal depression in many developing countries, UNFPA is working with WHO to accelerate the integration of mental health and psychosocial support into maternal health programmes. Integrating the prevention, diagnosis and treatment of sexually transmitted infections is essential to the sexual and reproductive health package. UNFPA works with Governments and other United Nations partners to increase access to and the quality of services related to sexually transmitted infections, including HIV prevention. UNFPA is also working to promote the priority linkages between sexual and reproductive health and HIV/AIDS. As part of the process of expanding access, UNFPA has supported the integration of the management of sexually transmitted infections into existing maternal and child health and/or family planning services. In Mongolia, UNFPA, in collaboration with the German Agency for Technical Cooperation (GTZ), is working to integrate diagnosis, treatment and counselling with respect to sexually transmitted infections and HIV in antenatal care and, jointly with the Global Fund, is introducing those services in adolescent health centres. In Zambia, UNFPA and WHO worked with the Ministry of Health to integrate the issues of sexually transmitted infections and HIV in family-planning protocols and training curricula for health providers.

39. UNFPA continues its work on the development and implementation of culturally sensitive reproductive health models, programmes and strategies as part of efforts to ensure equitable and appropriate care. In Latin America, efforts have focused on indigenous populations, with a view to addressing the poor indicators of reproductive health. In Mexico, UNFPA supported the development of two models for reaching indigenous migrant women, incorporating ancient medicinal practices. In Panama, UNFPA, in partnership with the International Fund for Agricultural Development, the Association of Ngobe Women and the Ministry of Health, continued its groundbreaking work, reaching indigenous women in 44 different Ngobe communities by incorporating traditional midwives in the labour process as cultural brokers between indigenous women and health personnel.

40. In emergencies and humanitarian crises, women, and in particular young people, are especially vulnerable to sexual violence and coercion, unintended pregnancy, pregnancy-related deaths and HIV infection and typically lack access to essential sexual and reproductive health services. UNFPA supports the integration of those services in the basic health package provided during times of humanitarian crisis, transition and recovery. UNFPA works closely with WHO and the Office of the United Nations High Commissioner for Refugees (UNHCR) within the Inter-Agency Standing Committee on Humanitarian Affairs in support of that mandate. At the country level, UNFPA works with multiple partners to ensure such access. In Afghanistan, UNFPA is helping to increase access to delivery care by supporting basic emergency obstetric-care centres, transportation for emergencies and training for midwives, nurses and doctors. In the Central African Republic, UNFPA has worked with national and international non-governmental organizations to

strengthen access to sexual and reproductive health care in conflict-affected zones by increasing the availability of emergency obstetric care, setting up mobile clinics and distributing male and female condoms and kits for delivery, and providing treatment and care in connection with sexually transmitted infections for survivors of gender-based violence. In the Sudan, UNFPA provides humanitarian support to prevent maternal death and disability in Darfur through the State Ministry of Health and non-governmental organization programmes, including training and the provision of equipment and supplies.

V. Millennium Development Goal 6: Combat HIV/AIDS, malaria and other diseases

41. The Programme of Action agreed to at the International Conference on Population and Development, along with benchmarks added at the five-year review of the Conference, informs the eight Millennium Development Goals and stresses that Governments need to ensure that the prevention of and services for sexually transmitted diseases and HIV/AIDS are an integral component of reproductive and sexual health programmes at the primary health-care level.⁵ In 2006, in a Political Declaration adopted at the General Assembly 2006 High-level Meeting on AIDS (General Assembly resolution 60/262, annex), Member States committed to taking extraordinary action to move towards universal access to HIV prevention, treatment, care and support by 2010. That commitment also recognized that halting and reversing the spread of AIDS was not only a goal in itself but also a prerequisite for achieving most other Millennium Development Goals.

42. The progress made since 2006 in the response to the HIV epidemic is evident in many regions. However, progress has been uneven, and the rate of expansion of the epidemic often outstrips the pace at which services are being brought to scale. In 2007, for every two persons who receive treatment, about five more individuals became newly infected with HIV. HIV infections in women are continuing to rise in every region of the world. In developing countries, young women represent about two thirds of all people aged 15 to 24 newly living with HIV, making them the most affected group in the world.⁶

43. Risk of and vulnerability to HIV infection are often determined by broad social forces and structural factors beyond the control of individuals. Poverty, gender inequalities and social marginalization make it difficult for individuals to reduce their risk or obtain essential HIV prevention, treatment, care and support services. As a result, the epidemic continues to spread, especially among women, owing to the deeper underlying factors of gender inequality, persistent stigma and discrimination against women and girls, and the lack of empowerment to reduce their vulnerability to HIV, even as many countries have accelerated their national responses.

44. The relationships between HIV and sexual and reproductive health are now well recognized. The majority of HIV infections are sexually transmitted or are

⁵ Economic and Social Commission for Asia and the Pacific, *Implementing the ICPD Agenda: 10 Years into the Asia-Pacific Experience* (2004) (United Nations publication, Sales No. 04.H.F.46 P).

⁶ See UNAIDS, *2008 Report on the Global AIDS Epidemic* (Geneva: UNAIDS, 2008).

associated with pregnancy, childbirth and breast-feeding. Additionally, sexual and reproductive ill health and HIV share root causes, including poverty, limited access to appropriate information, gender inequality, cultural norms and the social marginalization of the most vulnerable populations. Consequently, the implementation of the agenda of the International Conference on Population and Development is vital in the HIV/AIDS response. In keeping with the UNAIDS division of labour, UNFPA is leading efforts to strengthen prevention and sexual and reproductive health linkages, including with respect to reproductive-health-commodity security, condom programming, the prevention of gender-based violence, HIV and sex work, and the prevention of infection in women, including pregnant women and young people, and to strengthen the response to HIV/AIDS in the context of uniformed services and humanitarian crises.

45. UNFPA is working in close collaboration with Governments to strengthen and integrate reproductive health and HIV services. In Argentina, for example, UNFPA facilitated the dialogue between HIV and sexual and reproductive health services at the national, provincial and local levels. In Ghana, UNFPA was acknowledged by the Government as having been instrumental in promoting the integration of HIV into sexual and reproductive health services. In Malawi, UNFPA is providing long-term technical assistance to the Reproductive Health Unit of the Ministry of Health to strengthen the linkages between HIV and sexually transmitted infections and reproductive health services. In the Russian Federation, UNFPA initiated, jointly with the Ministry of Health, the development of a national strategy and a pilot project for integrated reproductive health and HIV services. In Zambia, UNFPA led the process of integrating the issue of HIV into Ministry of Health guidelines and training materials for family planning and sexually transmitted diseases.

46. UNFPA is working to improve access to reproductive health and HIV services for young people, women and girls in general and vulnerable groups in particular. As part of a comprehensive strategy to encourage access to and the use of sexual and reproductive health services, UNFPA collaborated with partners to develop country-level report cards on HIV prevention for young women and girls in 23 countries. The report cards have been used to target national, regional and international decision makers so as to increase and improve the programmatic, policy and funding actions taken with respect to HIV prevention for young women and girls. UNFPA worked with partners to issue action-oriented guidance on key topics, including preventing HIV in women and young girls and promoting young women's livelihoods to reduce their vulnerability to HIV. For example, in Malawi and Zambia, UNFPA has in the past two years provided technical support for the development of national youth policies and plans of action for the scaling up of sexual and reproductive health and HIV prevention services for young people.

47. As co-sponsor of UNAIDS, where the scale-up of services in connection with the prevention of mother-to-child transmission is an identified priority, UNFPA has provided support to 40 countries in the development of road maps within the new Africa maternal and newborn programme, contributing to such prevention. Additionally, sexual and reproductive health linkages to the prevention of mother-to-child transmission have been strengthened through indicator development, joint technical missions with WHO and UNICEF, support for inter-country workshops and the work of the Inter-Agency Task Team on Mother-to-Child Transmission.

48. To ensure an adequate supply of male and female condoms, UNFPA procured male condoms in 120 countries and female condoms in 50 countries and provided financial and technical support to countries enrolled in the Global Condom Initiative, including 22 in Africa, 23 in the Caribbean and 6 in Asia. For example, in Guatemala, UNFPA is the main partner for condom programming and assisted the Government in the provision and distribution of 6 million condoms in one year alone. Through the Female Condom Initiative, UNFPA has addressed the sexual and reproductive health needs of women in 23 countries by scaling up access, promoting the use of the female condom and ensuring that female-condom programming is an essential component of national AIDS policy guidelines and reproductive health programmes. UNFPA has supported condom forecasting in 89 countries and delivered emergency supplies of condoms to 28 countries to prevent condom stock-outs.

49. In close partnership with WHO, the International Labour Organization, UNESCO and the UNAIDS secretariat, UNFPA has facilitated global efforts to strengthen HIV prevention services as they relate to sex work. For example, in Argentina, UNFPA facilitated a national consultation on sex work and HIV. In Bangladesh, UNFPA provided technical assistance and funds to community-based organizations engaged in HIV prevention and treatment for sex workers and their clients. In Kenya, UNFPA supported the mapping of sex-work programmes and contributed to the development of a strategy for sex work and HIV interventions. UNFPA support also resulted in the Maputo Call to Action, providing a clear articulation of priority action areas. In Malawi, UNFPA supported the National AIDS Council and the Ministry of Health in a pilot project for the prevention of sexually transmitted infections and HIV among sex workers. In the Russian Federation, UNFPA supported the establishment of a network of non-governmental organizations and municipal clinics to offer sex workers prevention and care services for sexually transmitted infections and HIV. In Thailand, UNFPA has, inter alia, updated information on sexually transmitted diseases and HIV in sex-work settings and conducted surveys on sexual and reproductive health and sex workers.

50. HIV is not only a health and development issue but also a humanitarian and security one that needs to be addressed through systematic engagement with the international humanitarian system. To that end, UNFPA has been working closely with UNAIDS, the Department of Peacekeeping Operations, United Nations peacekeeping missions, national militaries and police forces to address the rampant spread of HIV/AIDS in security forces in many countries in Africa, Asia, Latin America and the Middle East. By integrating HIV/AIDS programming into initiatives for uniformed services, ex-combatants and women associated with armed groups, UNFPA engages high-risk populations in the process of actively combating the epidemic as agents of change in their communities. Specifically, UNFPA supported the development of training curricula and training and sensitization workshops on gender awareness and the prevention of HIV/AIDS and sexually transmitted infections within uniformed services, primarily in Côte d'Ivoire, Haiti, Lebanon, Sierra Leone and the Sudan. UNFPA supported the implementation of prevention programmes among national police forces, militaries and demobilized personnel, particularly in Côte d'Ivoire, the Democratic Republic of the Congo, Eritrea, Liberia, Sierra Leone, the Sudan, Turkey and Ukraine and in the Latin America and Caribbean region. In collaboration with UNDP, UNFPA has led work globally on HIV and disarmament, demobilization and reintegration programmes,

towards the integration and implementation of such programmes with reproductive health services. UNFPA has worked closely with UNHCR to provide reproductive health and HIV services to refugees and internally displaced persons in approximately 25 countries. UNFPA has also worked to build the capacity and raise the awareness of non-governmental organizations, Government and uniformed personnel with respect to HIV through workshops, trainings and the training of trainers.

51. In the context of United Nations reform and, specifically, in the wake of the UNAIDS division of labour and Global Task Team recommendations, it is evident that the contributions of UNFPA in support of the national HIV/AIDS response cannot be dissociated from or appraised independently of UNAIDS. In 2007 and 2008, UNFPA assigned more than 120 new staff in 70 countries and subregional offices to support national HIV prevention scale-up, with particular focus on most-at-risk and out-of-school young people. In every country in which joint United Nations teams on HIV/AIDS have been established, UNFPA is an active and engaged member, which has had an impact on the ability of UNFPA to support national ownership and development of the response.

VI. Millennium Development Goal 7: Ensure environmental sustainability

52. The Programme of Action of the International Conference on Population and Development, adopted in 1994, had already underscored the important linkages between population, sustained economic growth and sustainable development. Since then, however, the nature and scale of population-environment interactions have undergone significant transformations.

53. Traditionally, most attention has been focused on the impacts of population size and growth on the environment. World population has reached 6.7 billion and continues to grow by some 78 million people each year. Empowering women, reducing poverty and providing quality reproductive health services are all actions that are necessary in themselves and that would also accelerate the process of population stabilization, thereby helping to curb overall pressures on environmental resources, but only in the long run.

54. Current threats, particularly those posed by global climate change, now require that greater attention be focused on where, how and in which social groups this demographic growth occurs, rather than on absolute increments per se. The adoption by the world's developing areas of the consumption practices and living standards typical of the affluent would seriously deplete existing resources and risk endangering the global environment. Yet reducing poverty and improving people's lives remains an absolute priority.

55. Urban areas, which now harbour more than half of the world's population, account for much of the production and consumption processes that generate the greenhouse gases responsible for global warming. Many of these negative environmental consequences of urban growth could be mitigated by proactive attention to the sustainable use of space and to the land and housing needs of the poor.

56. Within this rapidly changing development context of population-environment interactions, UNFPA is supporting research to generate and disseminate an improved

understanding and awareness of the different ways in which population dynamics affect environmental change. The UNFPA agenda on climate change includes supporting research and advocacy for mitigation of climate change, promoting sustainable cities and reducing urban vulnerability, identifying the impacts of climate change on migration and improving responses to emergency situations. As a result, population issues were included in the Secretary-General's report on climate change that served to inform the United Nations Climate Change Conference, held in Bali, Indonesia, in 2007 and in Poznań, Poland, in 2008. UNFPA is working with other United Nations and international organizations in the positioning of population issues within the climate change framework.

57. In Bolivia, a joint effort between the Ministry of Planning and Development and the UNFPA country office resulted in the development of a situation analysis on population, town planning and the environment. In Colombia, UNFPA assisted in the development of a new approach to the linkages between population and environmental, social and economic issues in urban and regional planning. A draft report on urbanization in Eritrea was prepared in connection with the launch of the *State of World Population 2007* report, and the publication of technical programme updates on urbanization and partnerships drew policy attention to the issue of population and the environment.

58. In Morocco, the UNFPA country office was called upon to strengthen its advocacy with respect to newly emerging issues such as the linkage between population and the environment. In the Niger, a partnership with the Ministry of Education and UNDP made possible the implementation of an action plan on family life, education and the environment that will also integrate aspects of HIV/AIDS. In Sierra Leone, the UNFPA country office ensured that information on population and the environment would be reflected in the work of the United Nations country team and the national development agenda.

59. In Timor-Leste, urbanization and the linkage between population growth and the environment are of particular concern to the Government. In Uganda, population and the environment were identified as emerging issues, with a review process and the formulation of a five-year development plan scheduled to commence in 2008.

60. UNFPA will devote the *State of World Population 2009* report to the issues of environment and women in order to highlight the linkages between climate change and population factors.

VII. Conclusion

61. The Programme of Action of the International Conference on Population and Development clearly reflected the inextricable linkages between population, poverty, health, education, patterns of production and consumption and the environment. The guiding principles of the Conference placed national ownership and universally recognized human rights, equity and equality, most significantly gender equality, at the centre of social and economic development. Fifteen years have passed since then. As the international community observes the fifteenth anniversary of the Conference, it is clear that the Cairo development framework remains relevant and crucial to saving lives and advancing the quality of life of men, women and young people, in particular the most vulnerable populations. As detailed in the present report, the current strategic plan and programmes of UNFPA have

remained focused on supporting Governments in their efforts to achieve the objectives of the Conference and the Millennium Development Goals. UNFPA strategies continue to focus on coordination and collaboration with a wide range of partners, strengthening national capacity, investing in human resource development, the generation of data for policy formulation and analysis and for monitoring and evaluation systems, and facilitating technical support through national, regional and global networks, including South-South partnerships, advocacy and resource mobilization.

62. In the case of Goal 5, the progress made falls far short of achieving the objectives set. The addition to Goal 5 of the new target of universal access to reproductive health by 2015 has provided new momentum for addressing the health-related Millennium Development Goals through a comprehensive and integrated approach. There is sufficient evidence on how to improve maternal, newborn and child survival and reproductive health outcomes by scaling up access to an essential package of interventions delivered through a strengthened health system and targeting the poorest and most at-risk population. Achieving Goal 5 by 2015 will be possible only through the scaling up of country-level work, spearheaded by national leadership and ownership that guides investment in supportive pro-poor policies, strong health systems and effective interventions that are known to work, and supported by South-South cooperation for the exchange of lessons learned.

63. Much progress has been achieved in many areas related to the Millennium Development Goals, but such progress is uneven and much work remains to be done to realize both the goals of the International Conference on Population and Development and the Millennium Development Goals, especially in the poorest countries. A redoubling of efforts and a renewed commitment on the part of all stakeholders are essential to ensure the timely achievement of the internationally agreed development goals.

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**Flow of financial resources for assisting in the
implementation of the Programme of Action of the
International Conference on Population and Development****Report of the Secretary-General***Summary*

The present report responds to a request made at the twenty-eighth session of the Commission on Population and Development for an annual report on the flow of financial resources for assisting in the implementation of the Programme of Action of the International Conference on Population and Development. It also complies with General Assembly resolutions 49/128 and 50/124, in which the Assembly called for the preparation of periodic reports on the financial resource flows to assist in the implementation of the Programme of Action.

The report examines expected levels of donor and domestic expenditures for population activities in developing countries for 2007 and provides estimates for population expenditures in 2008 and projections for 2009. Donor assistance has been increasing steadily over the past few years, reaching \$7.4 billion in 2006. It is expected to surpass \$8 billion in 2007 and may further increase to \$11 billion over the next two years. These optimistic estimates presuppose that donors will continue to increase funding levels. A rough estimate of resources mobilized by developing countries, as a group, yielded a figure of \$18.5 billion for 2007. This number is expected to increase to \$19.6 billion in 2008 and \$20.5 billion in 2009. These figures also presuppose that developing countries will continue to increase resources for population activities. However, given the current global financial crisis, it is not certain whether countries will continue to increase funding levels for population.

* E/CN.9/2009/1.



Fifteen years have passed since the International Conference on Population and Development financial targets were fixed. Stocktaking of progress of the Conference 15 years after it was held shows that while resources mobilized have increased, the overall funding is significantly less than necessary to meet current needs and costs, which have grown tremendously since the targets were agreed upon in 1994. The goals and objectives of the Programme of Action of the Conference have not been fully implemented and although important progress has been made, fulfilling the commitments towards the Millennium Development Goals is not on track. A lack of adequate resources to meet current needs is a major impediment to the achievement of the goals of the Conference and the Millennium Development Goals.

In response to the International Conference on Population and Development call to review and update the cost estimates to ensure that current needs are met and to bring cost estimates more in line with funding needs for achieving the Millennium Development Goals, the report presents revised cost estimates for the four components of the International Conference on Population and Development population package. It points out that without political will, renewed commitment, and adequate resources to meet current needs, it will not be possible to achieve the goals of the Conference or the Millennium Summit.

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I. Introduction

1. The present report has been prepared by the United Nations Population Fund (UNFPA) in response to a request at the twenty-eighth session of the Commission on Population and Development¹ for an annual report on the flow of financial resources for assisting in the implementation of the Programme of Action of the International Conference on Population and Development held in Cairo in 1994.² The report is part of the work programme of the Commission on Population and Development and is submitted in accordance with General Assembly resolutions 49/128 and 50/124, which called for the preparation of periodic reports on the flow of financial resources for assisting in the implementation of the Programme of Action.

2. The report reviews the flow of funds from donor countries for population assistance in developing countries³ and provides estimates of government and non-governmental expenditures for population activities in developing countries for 2007. It also includes donor and developing country estimates for 2008 and projections for 2009. Data collection activities for both donor and domestic resource flows were undertaken by the Netherlands Interdisciplinary Demographic Institute under a contract with UNFPA. Evaluation and analysis of data were carried out jointly by UNFPA and the Netherlands Institute.

Methodology

3. A detailed questionnaire was mailed to over 100 key actors in the field of population and AIDS, including major multilateral organizations and agencies, large private foundations and other non-governmental organizations that provide substantial amounts of population assistance and Organization of Economic Cooperation and Development (OECD)/Development Assistance Committee (DAC) donor countries. To decrease respondent fatigue, coordinate monitoring of resource flows and ensure consistency in reporting, as much information from donor countries as possible is obtained from the OECD/DAC database. In the absence of complete data from a number of the major donors by the publication deadline, the information contained in this report is based on estimates taking into account past funding behaviour.

4. Information on domestic resource flows is based on data supplied by Governments and non-governmental organizations in developing countries throughout the world, secondary sources, and estimation and projections.

5. The external and domestic financial resource flows for population activities analysed in this report are part of the "costed population package" as specified in paragraph 13.14 of the Programme of Action of the International Conference on Population and Development. The package comprises family planning services;

¹ See *Official Records of the Economic and Social Council, 1995, Supplement No. 7 (E/1995/27)*, annex I, sect. III.

² *Report of the International Conference on Population and Development, Cairo, 5-13 September 1994* (United Nations publication, Sales No. E.95.XIII.18), chap. I, resolution I, annex.

³ All references to developing countries in this report also include countries with economies in transition.

basic reproductive health services; STDs/HIV/AIDS prevention activities;⁴ and basic research, data and population and development policy analysis. The Programme of Action estimated that the implementation of this population and reproductive health package in the developing countries and countries with economies in transition would cost \$18.5 billion annually by the year 2005 and \$20.5 billion by 2010. Approximately two thirds of the projected costs would come from developing countries and one third, or \$6.1 billion in 2005 and \$6.8 billion in 2010, would come from the international donor community.

II. Donor assistance to population activities

6. Donor assistance to population activities continues to increase. By 2006, it stood at \$7.4 billion. The provisional figure for 2007 is \$8.1 billion (see table 1). The 2008 and 2009 figures are projected to be about \$11 billion (see figure 1). However, given the current global financial crisis, it is not certain whether donors will live up to their expected future commitments and continue to increase funding levels as they have done in the past few years. It is possible that the final figures for 2008 and 2009 will show decreases in levels of funding for population assistance.

Table 1

International population assistance, by major donor category, 2006-2009

(Millions of United States dollars)

Donor category	2006	2007 (provisional)	2008 (estimated)	2009 (projected)
Developed countries	6,626	6,971	9,813	9,891
United Nations system	105	50	123	127
Foundations/NGOs	406	479	475	491
Development Bank grants	131	52	153	158
Subtotal	7,267	7,551	10,564	10,667
Development Bank loans	113	577	577*	577*
Total	7,380	8,129	11,141	11,244

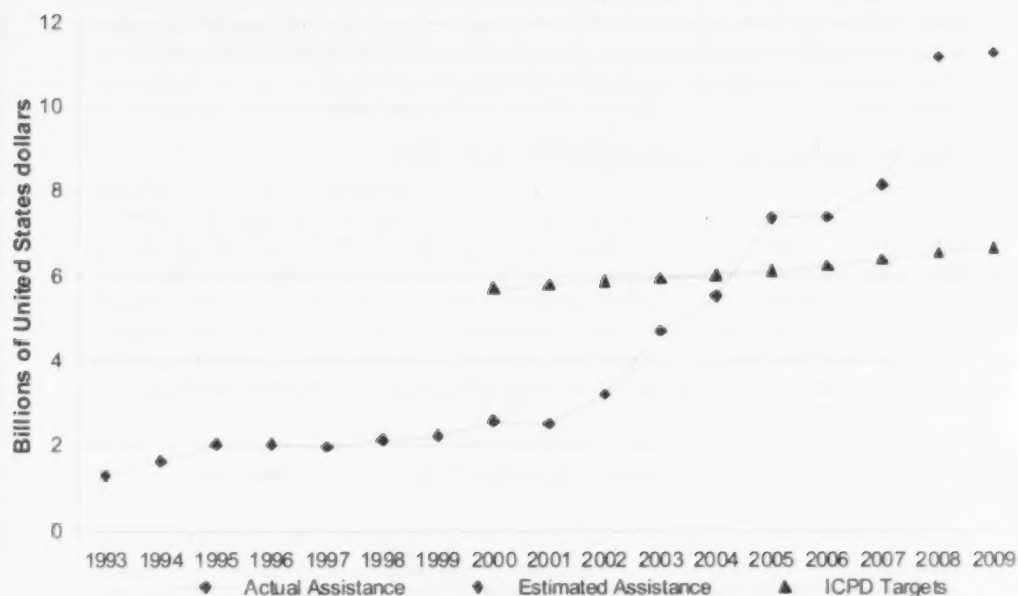
Source: UNFPA, 2008. *Financial Resource Flows for Population Activities in 2006 and Resource Flows Project database.*

Note: Totals may not add up due to rounding.

* The 2008-2009 figures for development bank loans are estimated at the 2007 level.

⁴ Beginning with the 1999 round of questionnaires, the Resource Flows Project began to include data on HIV/AIDS treatment and care to address the growing reporting needs of UNAIDS and because it was becoming increasingly impossible for respondents to provide information on HIV/AIDS prevention activities only.

Figure 1
Population assistance as compared with targets of the International Conference on Population and Development



Source: UNFPA, 2008. *Financial Resource Flows for Population Activities in 2006* and Resource Flows Project database.

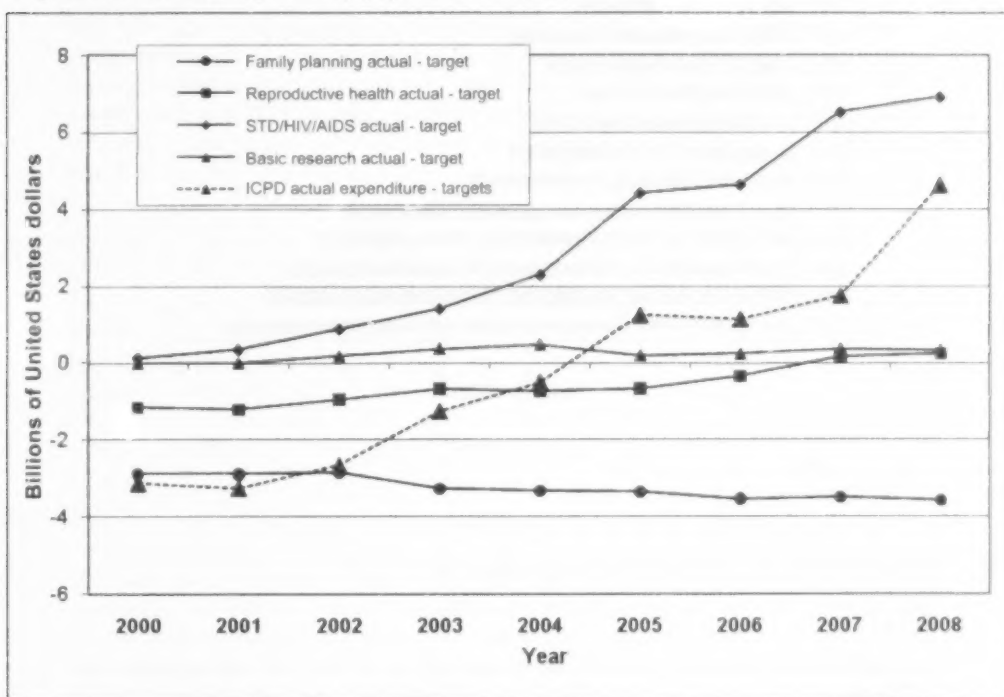
Note: Data on actual assistance for 2007 are provisional; data for 2008 are estimates; and data for 2009 are projections.

7. It is important to note that although the total financial target of the International Conference on Population and Development has been surpassed, a closer examination of how the funding is allocated over the four components of the Conference costed population package as compared with the specific targets for the individual categories shows that the increase in funding for HIV/AIDS obscures the fact that funding for the other components is below the agreed targets. Figure 2 compares actual population assistance with the Conference targets for family planning, reproductive health, STD/HIV/AIDS and basic research, data and population and development policy analysis. It is clear that funding levels for family planning are considerably below the Conference targets, while funding for STD/HIV/AIDS is substantially above the targets. Part of this difference may be explained by the fact that the targets of the International Conference on Population and Development for STD/HIV/AIDS included only prevention activities, while donors are currently reporting funding for treatment and care in addition to prevention activities because their accounting systems are such that they are not able to disaggregate resources that go to prevention activities and those that fund treatment and care. Funding for reproductive health has also been consistently below the Conference targets and has only slightly exceeded the target beginning with fiscal year 2007. Funding for basic research, data and population and development policy analysis has remained at or slightly above the Conference targets.

8. There are fears that the larger share of funding that goes to AIDS activities might distract attention for the necessary funding for the other three elements of the Conference costed population package. This is especially evident in the case of funding for family planning, where absolute dollar amounts are lower than they were in 1995. If not reversed, the trend towards less funding for family planning will have serious implications for the ability of countries to address unmet need for such services and could undermine efforts to prevent unintended pregnancies and reduce maternal and infant mortality.

Figure 2

Population assistance as compared with targets of the International Conference on Population and Development by population category



Source: UNFPA, 2008, *Financial Resource Flows for Population Activities in 2006* and Resource Flows Project database.

Note: Data on actual assistance for 2007 are provisional; data for 2008 are estimates.

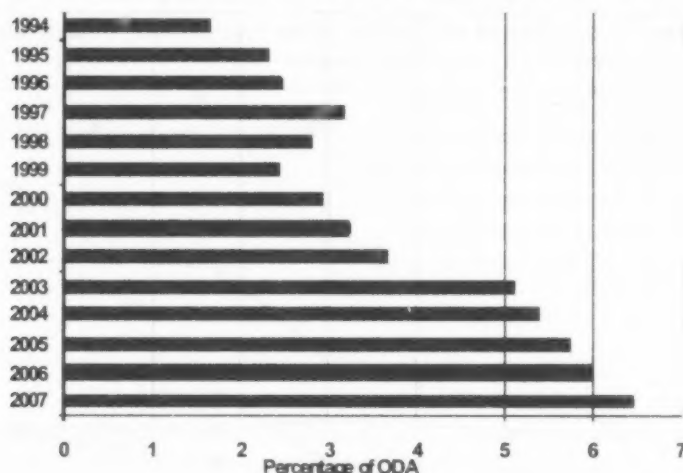
A. Bilateral assistance to population activities

9. Donor countries traditionally provide the largest share of population assistance. Bilateral assistance is estimated at \$7.0 billion in 2007, up from \$6.6 billion in 2006. According to preliminary estimates, donor countries provided \$9.8 billion for population activities in 2008. Projections for 2009 place this number at \$9.9 billion.

10. After several years of encouraging increases, official development assistance (ODA) decreased to \$103.5 billion in 2007 from \$103.9 billion in 2006. The percentage of total ODA that donor countries, as a group, contributed to population assistance increased to 6.46 per cent in 2007 from 6.07 per cent in 2006. There are significant variations between countries in percentage of ODA spent on population activities, from 0.11 per cent to 13.15 per cent.

Figure 3

Population assistance of donor countries as a percentage of ODA, 1994-2007



Source: UNFPA, 2008, *Financial Resource Flows for Population Activities in 2006 and Resource Flows Project database*.

Note: Data for 2007 are provisional.

B. Multilateral assistance to population activities

Grants

11. Multilateral assistance to population activities is provided by the organizations and agencies of the United Nations system, mainly from the Joint United Nations Programme on HIV/AIDS, UNFPA, the United Nations Children's Fund and the World Health Organization. Whatever the United Nations agencies receive for population assistance from OECD/DAC donor countries is considered to be bilateral assistance. General funds of agencies that are not earmarked for population activities, interest earned on funds and money from income-generating activities that are spent on population activities are considered as multilateral assistance for population. Funds received from developing countries that agencies spend on population activities are a small portion of the regular budget of an agency and are also included as multilateral assistance. Provisional figures for multilateral assistance show a substantial decrease, from \$105 million in 2006 to \$50 million in 2007. This is due in part to the fact that a number of United Nations agencies did not provide information by the publication deadline.

12. UNFPA is the leading provider of United Nations assistance in the population field, providing support to 159 developing countries in 2007. UNFPA, which relies on voluntary contributions, uses the multi-year funding framework initiative that emphasizes management for results, tying programme support to policy development and linking the International Conference on Population and Development and the Millennium Development Goals in the context of poverty reduction to stimulate resource mobilization.

Loans

13. Development banks, which provide loans to developing countries, are an important source of multilateral population assistance. Their contributions are treated separately from grants because their assistance is in the form of loans that must be repaid. The projects of the banks reflect multi-year commitments recorded in the year in which they are approved but disbursed over several years. Most loans for population assistance come from the World Bank, which supports reproductive health and family planning service delivery, population policy development, HIV/AIDS prevention, and fertility and health survey and census work. In 2007, the World Bank made available \$577 million in loans for population activities.

C. Private assistance to population activities

14. Foundations, non-governmental organizations and other private organizations are also important sources of population assistance. In 2007, it is estimated that foundations and non-governmental organizations contributed \$479 million to population activities, up from \$406 million in 2006. It is not certain how the current financial crisis will affect the level of private assistance to population activities in 2008 and 2009.

D. Expenditures for population activities by geographic region

15. Sub-Saharan Africa, which includes the majority of the least developed countries, continues to be the largest recipient of assistance, receiving more than half of all assistance going to the five geographic regions. Over 40 per cent of all population assistance goes to fund global and interregional population activities, including advocacy; research; reproductive health; support to the Global Fund to Fight AIDS, Tuberculosis and Malaria; HIV/AIDS prevention, care and support; and safe motherhood.

E. Expenditures for population activities by category of activity

16. UNFPA monitors expenditures for population activities by the following four International Conference on Population and Development costed population categories: (a) family planning services; (b) basic reproductive health services; (c) STD/HIV/AIDS activities; and (d) basic research, data and population and development policy analysis. The largest and increasing proportion of total population assistance goes to fund HIV/AIDS activities. Funding for family planning services decreased significantly from 40 per cent in 1997 to 5 per cent in 2007, while funding for basic reproductive health services decreased from 33 per

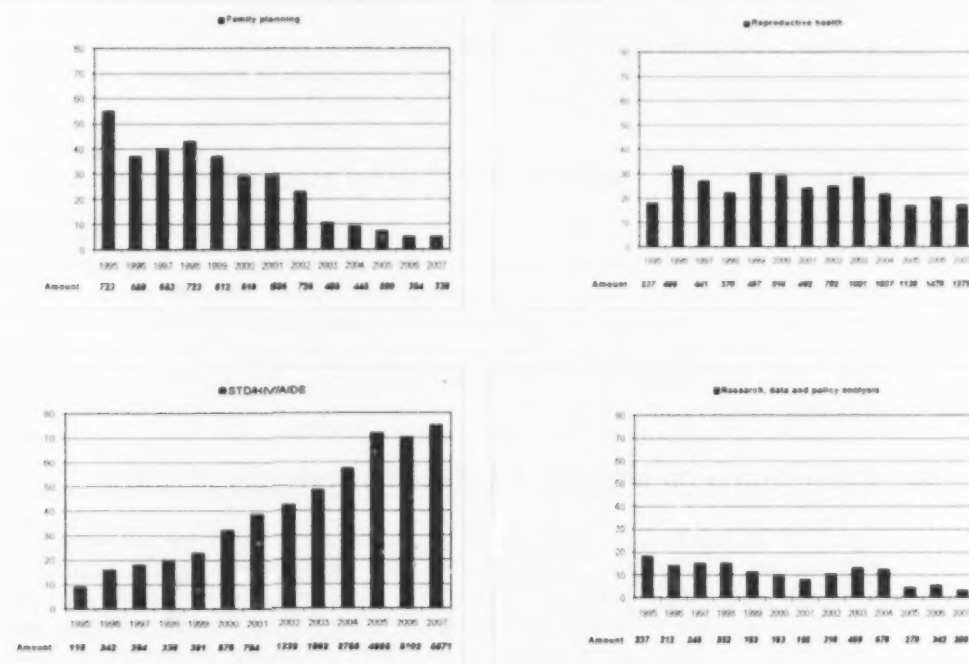
cent to 17 per cent during the same period. Consistent with the rapid spread of the HIV/AIDS pandemic, funding for HIV/AIDS activities increased sharply since 1997, from 16 per cent of total population assistance to 75 per cent in 2007. Funding for basic research activities decreased with fluctuations, from 15 per cent in 1997 to 3 per cent in 2007 (figure 4).

17. Funding for family planning services decreased in absolute dollar amounts since 1995 when UNFPA first began monitoring resource flows by the four International Conference on Population and Development costed population categories. Although funding for reproductive health and basic research activities increased, HIV/AIDS activities continue to receive by far the largest proportion of population assistance. Given the increased emphasis on addressing the global AIDS pandemic, including the Millennium Development Goal of combating HIV/AIDS, malaria and other diseases and the creation of the Global Fund to Fight AIDS, Tuberculosis and Malaria and the United States President's Emergency Plan for AIDS Relief, estimates for 2008 and projections for 2009 point to a continuation of this trend. In fact, donor countries are expected to continue to spend a large percentage of their population assistance on STD/HIV/AIDS activities in 2008 and 2009.

Figure 4

Expenditures for population activities as a percentage of total population assistance, 1995-2007

(Millions of United States dollars)



Source: UNFPA, 2008. *Financial Resource Flows for Population Activities in 2006 and Resource Flows Project database.*

18. The growing trend towards integration of services and the increasing use of sector-wide approaches in development assistance is making it increasingly difficult for countries to readily distinguish between expenditures for population and other health-related activities and, within population, between family planning, reproductive health and STD/HIV/AIDS activities.

F. Expenditures for population activities by channel of distribution

19. Assistance for population activities flows through a diverse network, moving from the donor to the recipient country through one of the following channels: (a) bilateral — directly from the donor to the Government of the recipient country; (b) multilateral — through United Nations organizations and agencies; and (c) non-governmental. The bilateral channel has overtaken the NGO channel that predominated during the past decade. In 2007, just under one third of population assistance was channelled by NGOs, compared to 41 per cent that went via the bilateral channel and 27 per cent that came from multilateral sources. This trend is expected to continue in 2008 and 2009 largely as a result of bilateral AIDS programmes.

III. Domestic expenditures for population activities

A. Methodology

20. Domestic resources of developing countries account for the largest portion of funds required to achieve population and development objectives. The mobilization of adequate domestic financial resources is essential to facilitating full implementation of the Cairo agenda. UNFPA has been monitoring domestic expenditures for population activities since 1997. This has been done primarily through the use of survey questionnaires sent to UNFPA Country Offices throughout the world for further distribution to Government ministries and large national NGOs. In many countries, local consultants were recruited to work with government authorities and NGOs in completing the questionnaires. Experience has shown that many Governments are often unable to supply the requested data because of funding, staffing and time constraints. In addition, countries that do not have well-developed systems for monitoring resource flows are unable to provide information, especially when funding is pooled in integrated social and health projects and sector-wide approaches. Furthermore, countries with decentralized accounting systems can supply data only on national expenditures, and are not able to provide information on expenditures for population at subnational (lower administrative) levels.

21. Total global domestic expenditures for population activities presented in the present report are estimated using a methodology that incorporates the responses of the surveyed countries, together with prior reporting on actual and intended expenditures, secondary sources on national spending, and, in the absence of such information, estimates and projections are based on national income as measured by

the level of gross domestic product (GDP) which proved the most influential variable explaining the growth of spending by Governments.⁵

B. Estimates and projections of domestic expenditures

22. Table 2 presents the latest estimates and projections of global domestic expenditures for population activities for 2007-2009. It shows an increase in domestic funding for population activities in all regions from 2007 to 2009. It is estimated that developing countries spent \$18.5 billion for population activities in 2007. The largest amount was mobilized in Asia (\$11.2 billion), followed by sub-Saharan Africa (\$3 billion), Latin America and the Caribbean (\$2.6 billion), Eastern and Southern Europe (\$922 million) and Western Asia and Northern Africa (\$839 million).

23. Domestic expenditures are estimated to have increased to \$19.6 billion in 2008 and they are projected to further increase to \$20.5 billion in 2009. Asia is expected to continue to mobilize the largest amount of financial resources in both 2008 and 2009. Sub-Saharan Africa is expected to mobilize the second largest amount of funds, followed by Latin America and the Caribbean. Eastern and Southern Europe ranks fourth in 2008 and fifth in 2009 after Western Asia and Northern Africa. Given the current global financial crisis, it is possible that resources will not reach projected levels.

24. Of all domestic expenditures for population 45 per cent was spent on STD/HIV/AIDS activities in 2007. This percentage varied considerably by region, from over 92 per cent in sub-Saharan Africa to 22 per cent for Asia and the Pacific. Figures for Asia are low because data on out-of-pocket spending are not complete.

Table 2

Projection of global domestic expenditures for population activities, 2007-2009

(Thousands of United States dollars)

Year	Source of funds			Percentage spent on	
	Government	NGO	Consumers*	Total	STD/HIV/AIDS
2007					
Africa (sub-Saharan)	1 359 816	118 814	1 490 314	2 968 944	92
Asia and the Pacific	3 169 144	135 987	7 872 153	11 177 284	22
Latin America and the Caribbean	1 594 955	129 196	826 184	2 550 335	85
Western Asia and North Africa	479 915	49 543	309 545	839 003	29

⁵ See Erik Beekink and Annemarie Ernsten, *Projections of Funds for Population and AIDS Activities, 2007-2009*, The Hague, 2008; Marieke van der Pers and Erik Beekink, *Projections of Funds for Population and AIDS Activities, 2006-2008*, The Hague, 2007; Hendrik van Dalen and Daniel Reijer, *Projections of Funds for Population and AIDS Activities, 2005-2007*, The Hague, 2006; Hendrik van Dalen and Mieke Reuser, *Projections of Funds for Population and AIDS Activities, 2004-2006*, The Hague, 2005 and Henrik van Dalen and Mieke Reuser, *Assessing Size and Structure of Worldwide Funds for Population and AIDS Activities*, The Hague, 2004.

Year	Source of funds			Percentage spent on	
	Government	NGO	Consumers*	Total	STD/HIV/AIDS
Eastern and Southern Europe	598 943	14 373	308 456	921 772	75
Total	7 202 773	447 913	10 806 651	18 457 338	45
2008					
Africa (sub-Saharan)	1 378 101	132 589	1 509 223	3 019 913	91
Asia and the Pacific	3 435 751	145 579	8 534 406	12 115 736	19
Latin America and the Caribbean	1 600 051	134 015	839 864	2 573 930	83
Western Asia and North Africa	554 777	55 822	357 831	968 429	28
Eastern and Southern Europe	629 154	16 219	324 014	969 387	73
Total	7 597 833	484 224	11 565 338	19 647 395	41
2009					
Africa (sub-Saharan)	1 386 251	138 245	1 517 645	3 042 141	91
Asia and the Pacific	3 636 998	151 206	9 034 302	12 822 506	18
Latin America and the Caribbean	1 605 960	135 579	844 333	2 585 872	83
Western Asia and North Africa	575 805	57 797	371 394	1 004 996	28
Eastern and Southern Europe	646 348	16 987	332 869	996 205	72
Total	7 851 362	499 814	12 100 544	20 451 720	40

Source: Erik Beekink and Annemarie Ernsten, *Projections of Funds for Population and AIDS Activities, 2007-2009*, The Hague, 2008. See also Marieke van der Pers and Erik Beekink, *Projections of Funds for Population and AIDS Activities, 2006-2008*, The Hague, 2007; Hendrik van Dalen and Daniel Reijer, *Projections of Funds for Population and AIDS Activities, 2005-2007*, The Hague, 2006; Hendrik van Dalen and Mieke Reuser, *Projections of Funds for Population and AIDS Activities, 2004-2006*, The Hague, 2005; and Hendrik van Dalen and Mieke Reuser, *Assessing Size and Structure of Worldwide Funds for Population and AIDS Activities*, The Hague, 2004.

* Consumer spending on population activities covers only out-of-pocket expenditures and is based on the average amount per region as measured by the WHO (2004) for health-care spending in general. For each region, the ratio of private out-of-pocket versus per capita government expenditures was used to derive consumer expenditures in the case of population activities.

C. Components of domestic funding for population activities

25. Governments play a major role in financing population programmes and are considered to be responsible for most domestic expenditures for population activities. However, since the level of government funding usually depends on the level of national income, Governments in least developed countries are least likely to afford large outlays for population activities. Poor countries faced with many competing development priorities cannot afford to make the necessary investments in population. As a result, population issues are often excluded from social and health sector programmes because there is not enough funding, or because of the emergence of new priorities without safeguards to ensure sustainability and expansion of existing programmes. National NGOs also contribute financial

resources for population, but the majority of them are highly dependent on international resources. Their main role lies in advocacy work and in reaching people at the grass-roots level.

26. National Governments and NGOs are not the only sources of domestic expenditures for population activities. Consumer spending as measured by out-of-pocket expenditures represents the largest part of resources spent on population activities. Private consumer expenditures account for a large percentage of total funding for health care. Although exact amounts of worldwide health-care spending for population activities are not known, it stands to reason that a significant proportion of expenditures for family planning, reproductive health and STD/HIV/AIDS services are borne by consumers. The few available sources of information on private spending reveal great variations between regions and countries and, in some cases, changes over time in the share of private spending within countries themselves. In estimating consumer spending, the Resource Flows Project used out-of-pocket health expenditures of households from the national health accounts figures as collected by WHO. The out-of-pocket health expenditures were assumed to be completely in line with out-of-pocket expenditures for population goods and services.

27. Funding behaviour is not easy to predict. Figures for 2008 and 2009 are dependent on whether Governments follow the expected patterns of spending given past reported expenditures and levels of national income and whether they live up to their commitments. Unforeseen factors such as natural disasters, conflict and political unrest can have a significant impact on domestic spending for population. On the other hand, such events can also serve to increase international assistance. The current global financial crisis may affect the amount of financial resources that Governments will be able to allocate to population activities.

28. Although the global figure of domestic resource flows is a rough estimate, it is the most plausible estimate, given the fact that data are often incomplete and not entirely comparable. The information is useful in that it provides some idea of the progress made by developing countries, as a group, in achieving the financial resource targets of the Programme of Action of the International Conference on Population and Development. While the global total shows real commitment on the part of developing countries, it conceals the great variation that exists among countries in their ability to mobilize resources for population activities. Most domestic resource flows originate in a few large countries. Many countries, especially those in sub-Saharan Africa and the least developed countries, are not able to generate sufficient resources to finance their own population programmes and rely heavily on donor assistance.

IV. Revised cost estimates to meet current needs

29. The financial targets of the International Conference on Population and Development were fixed some 15 years ago and do not meet current needs that have grown dramatically since the targets were agreed upon. At that time, the population and health situation in the world was much different from what it is today. The HIV/AIDS crisis is far worse than anticipated, and infant, child and maternal mortality remains unacceptably high in many parts of the world. Health-care costs have increased dramatically and the lack of progress on Conference targets has been

identified as being linked to a number of issues including the lack of investment in the development and support of health systems and programmes. As many countries around the world prepare for the 2010 round of censuses, costs of data collection and dissemination have risen substantially. In addition, the value of the dollar today is far lower than it was in 1993. As a result, the Conference targets of \$18.5 billion in 2005 and \$20.5 billion in 2010 are simply not sufficient to meet the current needs of developing countries in the area of family planning, reproductive health, STD/HIV/AIDS and basic research, data and population and development policy analysis.

30. The escalating costs and needs, as compared with original Conference estimates, call for a review and update of the resource requirements to finance population and reproductive health programmes in developing countries today. Sufficient resources must be mobilized to fully implement the Conference agenda. This is particularly important if the international community is to achieve the Millennium Development Goals. Indeed, population and reproductive health are central to development and the achievement of the Millennium Development Goals. At the 2005 World Summit, world leaders committed themselves to achieving "universal access to reproductive health by 2015, as set out at the International Conference on Population and Development, integrating this goal in strategies to attain the internationally agreed development goals, including those contained in the Millennium Declaration, aimed at reducing maternal mortality, improving maternal health, reducing child mortality, promoting gender equality, combating HIV/AIDS and eradicating poverty" (General Assembly resolution 60/1, para. 57 (g)).

31. In response to the call in paragraph 13.15 of the Programme of Action of the Conference that the "estimates should be reviewed and updated" and to harmonize the Conference financial targets with Millennium Development Goals costing, UNFPA undertook the task of reviewing estimates for the four components of the International Conference on Population and Development costed population package and produced revised estimates to meet current costs and needs. The results of this exercise appear in Table 3.

Table 3
Revised ICPD cost estimates, by subregion, 2009-2015
(Millions of United States dollars)

<i>Region/year</i>	<i>2009</i>	<i>2010</i>	<i>2011</i>	<i>2012</i>	<i>2013</i>	<i>2014</i>	<i>2015</i>
Global	48 980	64 724	67 762	68 196	68 629	69 593	69 810
Sexual/reproductive health/family planning	23 454	27 437	30 712	32 006	32 714	33 284	33 030
Family planning direct costs	2 342	2 615	2 906	3 209	3 529	3 866	4 097
Maternal health direct costs	6 114	7 868	9 488	11 376	13 462	15 746	18 002
Programmes and systems-related costs	14 999	16 954	18 319	17 422	15 723	13 672	10 931
HIV/AIDS	23 975	32 450	33 107	33 951	34 734	35 444	36 189
Basic research/ data/policy analysis	1 551	4 837	3 943	2 239	1 181	864	591
Sub-Saharan Africa	20 063	27 075	29 473	29 869	30 292	30 022	28 980
Sexual/reproductive health/family planning	8 482	10 612	12 596	12 675	12 764	12 184	10 731
Family planning direct costs	329	414	506	606	713	827	931
Maternal health direct costs	1 429	1 833	2 280	2 771	3 306	3 883	4 411
Programmes and systems-related costs	6 725	8 366	9 809	9 298	8 746	7 473	5 389
HIV/AIDS	11 228	15 891	16 227	16 746	17 243	17 638	18 110
Basic research/ data/policy analysis	353	571	651	449	285	200	139
Asia and the Pacific	17 549	23 281	23 923	23 788	23 862	24 415	25 245
Sexual/reproductive health/family planning	9 055	10 278	11 027	11 753	12 124	12 820	13 533
Family planning direct costs	1 434	1 552	1 675	1 803	1 937	2 077	2 156
Maternal health direct costs	2 799	3 664	4 299	5 110	6 018	7 024	8 054
Programmes and systems-related costs	4 822	5 062	5 053	4 840	4 169	3 719	3 323
HIV/AIDS	7 853	10 687	10 848	11 048	11 207	11 409	11 525
Basic research/ data/policy analysis	641	2 316	2 048	987	530	186	187
Latin America and Caribbean	6 366	7 591	7 439	7 775	7 699	7 966	8 320
Sexual/reproductive health/family planning	3 132	3 401	3 627	3 837	3 922	4 119	4 347
Family planning direct costs	310	343	378	414	452	492	518

<i>Region/year</i>	<i>2009</i>	<i>2010</i>	<i>2011</i>	<i>2012</i>	<i>2013</i>	<i>2014</i>	<i>2015</i>
Maternal health direct costs	958	1 182	1 431	1 706	2 009	2 340	2 680
Programmes and systems-related costs	1 864	1 876	1 818	1 717	1 461	1 286	1 150
HIV/AIDS	3 072	3 461	3 562	3 630	3 703	3 770	3 867
Basic research/ data/policy analysis	162	729	250	309	74	78	106
Western Asia and Northern Africa	2 795	3 685	3 418	3 538	3 501	3 865	3 721
Sexual/reproductive health/family planning	1 852	2 009	2 130	2 232	2 258	2 339	2 415
Family planning direct costs	178	204	231	261	292	325	346
Maternal health direct costs	603	735	873	1 019	1 171	1 328	1 471
Programmes and systems-related costs	1 071	1 070	1 025	953	796	686	598
HIV/AIDS	798	1 095	1 112	1 131	1 146	1 163	1 183
Basic research/ data/policy analysis	145	582	177	174	97	363	123
Eastern and Southern Europe	2 204	3 091	3 508	3 226	3 275	3 326	3 542
Sexual/reproductive health/family planning	933	1 137	1 334	1 510	1 645	1 824	2 004
Family planning direct costs	91	103	116	125	135	145	146
Maternal health direct costs	324	454	605	771	960	1 171	1 386
Programmes and systems-related costs	517	579	613	614	551	508	471
HIV/AIDS	1 023	1 316	1 358	1 397	1 435	1 465	1 503
Basic research/ data/policy analysis	248	638	816	320	195	38	35

32. As expected, the revised estimates are much higher than the original targets of the International Conference on Population and Development agreed upon in 1994 because they take into account both current needs and current costs. As in accordance with past practice, these costs do not take inflation into account. The costs are considered minimum estimates required to implement the goals of the International Conference on Population and Development in the areas of family planning, reproductive health, STD/HIV/AIDS and basic research, data and population and development policy analysis. There will always be unspecified costs that fall outside the scope of the cost estimates as well as adjustments for, among other things, demand generation and stock maintenance.

33. The costing estimates for family planning assume that the current unmet need will be satisfied in 2015 although there is likely to be greater demand for family planning as people become more aware of the options. The costing estimates for reproductive health include antenatal care, delivery care, obstetric complications care, newborn interventions, reproductive organ cancer screening and treatment, as well as other maternal care interventions. STD/HIV/AIDS costing includes elements for prevention, treatment, care and support, including elements specifically to address issues of prevention of violence against women.

34. The cost estimates for the drugs, supplies and personnel needed to achieve the goals of the Conference increase significantly over time owing to the increased number of people projected to be receiving care as service coverage is scaled up as well as underlying population increases.

35. Health systems and programme costs related to family planning and reproductive health were estimated to reflect the need for a significant investment in the health systems and planning in order to achieve the Conference goals of universal coverage. Without adequate investment in the health systems and programmes, it will be impossible to achieve the coverage goals. Elements included in this cost estimation include programme management, supervision, health education, monitoring and evaluation, advocacy, health system infrastructure, information systems, human resources training and commodity supply systems. The cost estimates for the health systems and programmes assume that the bulk of the investment will be made between 2009 and 2013. As a result of this assumption, the cost estimates for the health systems and programmes elements peak in 2011 and then begin to decline. Cost estimates also include support during humanitarian crisis situations that are an ongoing challenge to medical systems in many countries.

36. Total costs for sexual/reproductive health, which includes the family planning and maternal health components (including direct costs and programme and systems costs), are estimated to be \$23.5 billion in 2009, peak at \$33.3 billion in 2014 and decrease slightly to \$33 billion in 2015. Total costs for the HIV/AIDS component are estimated to be \$24 billion in 2009 and increase each year thereafter, until they reach \$36.2 billion in 2015.

37. The estimates for the basic data, research and population and development policy analysis component were obtained by summing four expenditure categories: censuses, surveys, civil registration, and research and training. Census expenditures were based on per capita census costs by subregion, which varied from \$1.50 in Eastern, Middle, and Northern Africa to \$11.70 in Southern Europe. The total was then allocated to a four-year period: 10 per cent in the year before the census, 60 per cent in the census year, and 15 per cent in each of the two years after the census. Survey costs were estimated at \$1.25 or \$1.50 per household, depending on the subregion, while the household sample sizes were estimated at 1 per cent, 0.5 per cent, or 0.25 per cent, depending on whether the country had less than a million, from 1-25 million, or more than 25 million inhabitants. Furthermore, it was assumed that all developing countries should have a survey of this kind once every 4 years. For civil registration costs, it was assumed that the cost of processing each event (births, deaths, marriages, divorces) and entering it into the statistical system is one third of the per capita census costs for each subregion. The expenditures for research and training were computed as 5 per cent of the total average annual costs of the previous three categories over the period from 2005 to 2015.

38. The results are considerably higher than earlier estimates. The more important reason is that the present figures reflect the real costs of census-taking to a much larger degree than previously. This affects in particular the year 2010, when total expenditures will reach \$4.84 billion, of which \$4.41 billion will be census expenditures. On the whole, census expenditures make up about three quarters (75.8 per cent) of the total, surveys 6.9 per cent, and civil registration 12.5 per cent. The average annual expenditure over the seven-year period is estimated to be \$2.17 billion.

39. Current funding levels are far below the revised cost estimates. It is estimated that about 11 per cent of the revised costs of family planning/reproductive health, 35 per cent of HIV/AIDS, and 14 per cent of data and research will be covered by population assistance in 2009. It is harder to predict the amount of domestic resources that will be mobilized for the separate components of the International Conference on Population and Development. It is clear that funding levels will not be sufficient to meet current requirements. Both donor and domestic funding should be increased in all four components of the Conference costed population package to ensure implementation of the Conference goals and the achievement of the Millennium Development Goals.

40. Because of a strong commitment on the part of the international community, the largest percentage of funding currently goes to STD/HIV/AIDS activities. However, the lack of adequate funding for both family planning and reproductive health will undermine efforts to prevent unintended pregnancies and reduce maternal and infant mortality. Rising costs of data collection require adequate resources to ensure that countries conduct periodic censuses and surveys, maintain civil registration systems, and provide the necessary training and support for research to inform policymaking and programme planning.

V. Conclusion

A. Progress in resource mobilization

41. The International Conference on Population and Development at 15 presents a good opportunity to take stock of progress towards the achievement of the financial targets agreed upon in Cairo. There has been an increase in the flow of financial resources for assisting in the implementation of the Conference Programme of Action, but this has been primarily a result of the increase in funding for HIV/AIDS activities, including both prevention and treatment. But even these increases do not meet current HIV/AIDS needs that are much higher than had been anticipated when the targets were set. Funding for family planning, which has been steadily decreasing, is significantly below the suggested Conference targets and is not meeting current needs in this area either. Additionally, there has not been sufficient investment in the health systems of developing countries to enable the achievement of the Conference targets. The population and health situation in the world was much different when those targets were agreed upon in 1994 from what it is today. No one had foreseen the escalation of the AIDS pandemic. Health-care costs have skyrocketed since then. In addition, the lack of sufficient investment in the first 15 years since the Conference has left many countries well behind the pace for achieving the targets and requiring significant investment to accelerate progress. As

a result, the Conference targets are not sufficient to meet the current needs of developing countries.

42. The revised cost estimates presented in this report are more in line with the Millennium Development Goals costing and are intended to more accurately reflect the necessary financial resources currently needed to facilitate the achievement of the targets of the Conference and the Millennium Development Goals. Current funding levels are much below the revised and more realistic targets necessary to realize the Conference goals and achieve the Millennium Development Goals. This is true for all four components of the costed population package. The lack of adequate funding remains the chief constraint to the full implementation of the goals of the International Conference on Population and Development and the Millennium Summit.

B. Key areas requiring further attention

43. Continued resource mobilization advocacy efforts on the part of both donors and developing countries are essential to fully implement the Conference agenda and achieve the Millennium Development Goals. Implementing the Conference Programme of Action, especially the reproductive health goal, is essential for meeting the Millennium Development Goals directly related to health, social and economic outcomes, especially those in the areas of children, mothers, HIV/AIDS, gender and poverty.

44. The challenge before the international community at ICPD at 15 is to reaffirm its commitment to the achievement of the Cairo goals and the Millennium Development Goals by mobilizing the resources required in all areas of the costed population package of the International Conference on Population and Development: family planning services, reproductive health services, STD/HIV/AIDS activities and basic research, data and population and development policy analysis. Without political will and a firm commitment to population, reproductive health, and gender issues, it is unlikely that the goals and targets of the International Conference on Population and Development and the Millennium Summit will be met.